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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in December  
2013 while in the custody of HMP & YOI Doncaster**

## ***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 investigation report into the death of a man in December 2013, while a prisoner at HMP Doncaster. The man died from multi-organ failure. He was 63 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Doncaster. The prison cooperated fully with the investigation.

The man had a mini-stroke in 2003 and took medication to regulate his blood pressure and for high cholesterol from then until his death. He consistently complained of leg pain and cramps, for which he received a heat cream and medication to alleviate his symptoms. From October 2013, his mobility worsened and he began to rely on a wheelchair and help from a prisoner carer.

On 10 December 2013, the man was found unwell in his cell. Nurses referred him to the prison doctor who suspected a stroke and sent him to hospital. At hospital, the man was diagnosed with a blockage in the aortic artery which required major surgery. The man wanted time to think about this, but the next day a consultant told him that his condition had deteriorated significantly and surgery was no longer possible. He told the man that he had just weeks to live and would be treated palliatively. He remained in hospital until he died.

The clinical reviewer considered that, with the man's medical history, the possibility of a referral to a vascular surgeon should have been considered earlier. The prison did not request his community medical records when he arrived, which might have shown this needed to be followed up. While it would not have affected the outcome for the man, nurses should have reacted more quickly when prison officers raised concerns about the man's condition on 10 December. The clinical reviewer concluded that the overall care the man received from prison health services was not comparable to community standards. I also do not consider that the use of restraints when the man was taken to hospital was always justified by fully considered risk assessments.

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**

**April 2015**

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## SUMMARY

1. The man was convicted of serious sexual offences on 1 July 2003 and sent to HMP Frankland. He suffered a stroke in 2003 and from then onwards took medication for blood pressure and high cholesterol. In 2008 and 2009, he complained of pain and cramps in his legs, for which he received a heat rub cream and medication to alleviate cramp. In March 2012, the man was conditionally released from prison, but was recalled on 9 August after he breached a restraining order. He was sent to HMP Doncaster.
2. Over the next 14 months the man continued to have pains in his legs and his mobility worsened. From October 2013, his mobility deteriorated and, from November, he spent most of his time in his cell. He used a wheelchair to get about and a prisoner carer assisted him with daily tasks.
3. At about 8.30am on 10 December 2013, the man's prisoner carer found him confused and uncoordinated. An officer rang the prison healthcare centre to ask for someone to examine him, and a nurse saw him later that morning and referred him to the doctor. The doctor examined him and suspected the man had suffered a stroke. He was taken to hospital that afternoon.
4. The man was escorted by two officers and restrained by an escort chain on his way to hospital. He was admitted to hospital and remained restrained until 15 December, five days before he died.
5. On 11 December, the man was told that he required major surgery and amputation of his leg. He wanted time to consider this, but the next day a hospital consultant decided that he was too ill for an operation. The consultant told the man he had a matter of weeks to live. On 16 December, the man applied for release on compassionate grounds, but died on 20 December, before a decision had been made.
6. The man had not been in contact with his son for some years, but asked the prison to contact him. It took some days to trace him, but his son was found and was able to visit him in hospital two days before his death.
7. The clinical reviewer concluded that the man did not receive treatment that was comparable to that he could have expected to receive in the community. He noted that, with his medical history, the possibility of referring him to a vascular surgeon at an earlier stage should have been considered. Had the prison requested his community medical records they might have indicated that this needed to be followed up. We do not consider that healthcare staff at the prison responded with sufficient urgency when prison officers reported concerns to them. We are not satisfied that the use of restraints when the man was taken to hospital was justified by a fully considered risk assessment that took account of his health and mobility at the time. Although well supported by the Director's personal assistant, we consider that a trained family liaison officer should have been available. We make six recommendations.

## THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and inviting anyone who had relevant information to contact him. One prison custody officer contacted him.
9. The investigator obtained copies of the man's prison and prison medical records. He interviewed four prison staff and one prisoner at HMP Doncaster on 25 February. He gave the prison initial feedback about the preliminary findings of the investigation and updated that information as the investigation progressed.
10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The report was received on 24 April 2014, a supplementary report was received on 9 May 2014 and a letter from the clinical reviewer with additional evidence was received on 26 September 2014.
11. We informed HM Coroner for Doncaster of the investigation who provided the cause of death. We have sent the Coroner a copy of this investigation report.
12. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin, to explain the investigation. The man's son was concerned that his father did not receive appropriate care at the right time and that he should have been sent to hospital when he appeared to be unwell on 8 December.
13. The man's family's solicitors had some questions when the original draft report was issued in May 2014. As a result the clinical reviewer revised his findings and amended the original clinical review and issued a supplementary report. This is a redrafted report which takes account of the revised clinical review and includes the additional evidence from the clinical reviewer as an annex.
14. The man's family received a copy of the draft report. The solicitor representing the man's family wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
15. The draft report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been added to the end of this report.
16. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate care was provided, his location, security arrangements for hospital escorts, liaison with his family and whether compassionate release was considered.

## **HMP & YOI DONCASTER**

17. HMP & YOI Doncaster is a Category B local prison which can hold up to 1,145 men. The prison is managed under contract by Serco Home Affairs. Healthcare is provided by NHS Nottinghamshire Trust.

### **HM Inspectorate of Prisons**

18. The most recent inspection of HMP Doncaster was in March/April 2014. The Inspectorate found that many fundamental aspects of healthcare delivery were satisfactory but this was undermined by the unprofessional behaviour of some healthcare staff. There was a carer scheme, and prisoner diversity representatives supported older prisoners and those with disabilities. A wide range of clinics and screening services were run and waiting lists were short. Access to a GP was reasonable.

### **Independent Monitoring Board**

19. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to September 2013, the Board noted that Nottinghamshire NHS Trust had vastly improved its procedures and this was reflected across the prison. The IMB was satisfied that prisoners received appropriate healthcare.

### **Previous deaths at HMP Doncaster**

20. The man was the third prisoner to die at Doncaster from natural causes since the start of 2011. There were no similarities between the cases.

## ISSUES

### Diagnosis of the man's terminal illness and informing him of his condition

21. Records show that the man suffered a transient ischaemic attack (TIA – Mini stroke) in 2003. From that time, he took medication to manage his blood pressure and cholesterol levels. The man first reported pain in his legs in September 2008, for which he received a heat rub lotion

In March 2012, the man was released on licence, but was recalled to prison on 9 August 2012 and sent to HMP Doncaster. At a reception health screen, the man reported continued problems with his legs, but his description of the pain was vague. He was noted to be generally frail and unsteady on his feet. He said that he had a hospital appointment in August or November (he was not sure) and that he had had a CT scan while he had been released. The clinical reviewer noted that a podiatrist had seen him in July 2012 while he was in the community and recorded problems with the arteries in his legs. It does not appear that healthcare staff followed up the hospital appointment and CT scan or request his community medical records.

22. A second health screen on 11 August noted that the man's parents had a history of heart disease and that he was a long term smoker. The man continued to complain of leg pain and received heat rub cream. In January 2013, cholesterol level and blood pressure checks indicated no problems. On 25 February, an annual review in relation to his earlier stroke found no problems. The man declined any help to give up smoking.
23. On 30 July, the Team Manager saw the man after he complained of cramps in his legs. A prison GP prescribed heat rub cream later that day and noted that leg pain was an on going problem. (The man continued to be prescribed aspirin, simvastatin and heat rub cream until he went to hospital on 10 December 2013.)
24. On 10 October, the prison disability officer advised healthcare staff that the man had difficulty mobilising and he was referred to a physiotherapist for assessment. He was given a wheelchair and allocated a prisoner carer to help with daily tasks. The man's carer told us that the man became cell-bound in November because his mobility was so poor. On 2 December, a physiotherapist saw the man and noted he was unsteady on his feet. The man wanted a wheelchair, but the physiotherapist wanted him to try using crutches first. The man said that he had had a scan at the hospital in 2012 and the physiotherapist noted that information about this should be sought from Doncaster Royal Infirmary. There is nothing in the record to indicate this was followed up.
25. On the morning of 8 December, the officer was concerned that the man did not look well. He told nurses on the wing and noted his concerns in the unit handover book. It appears that a nurse saw the man later that day, but did not record anything in his medical records. The next day, a nurse saw the

man about the pain in his legs. Although she noted he was unsteady on his feet, she had no major concerns.

26. At about 8.30am on 10 December, the man's prisoner carer told the officer that the man was slumped in his chair and unwell. The officer found the man with his upper body resting on his bed. His face was grey and he had soiled himself. The officer telephoned the healthcare centre and asked for someone to attend. She was told to contact the wing nurse who said she would come after she had completed dispensing methadone.
27. The man's carer cleaned and changed him. The officer periodically checked the man and was concerned that after two hours a nurse had still not seen him. The unit manager telephoned the healthcare centre and the nurse saw the man at about 11.55am. She noted he had no strength and appeared confused and uncoordinated. She referred him to see the prison GP later that day.
28. A GP saw the man at 1.53pm and suspected he had suffered a stroke and referred him to hospital. The man left the prison at 3.23pm by taxi and was taken to Doncaster Royal Infirmary, where he was admitted.
29. After tests, hospital staff told the man there was a blockage in his abdominal aorta and this had caused severe renal damage and loss of tissue in both legs and groin area. A surgeon advised the man that his right leg needed to be amputated and he needed major arterial by-passes. The man initially declined to have the operation and wanted time to consider.
30. On 12 December, a vascular consultant told the man that the problem now affected both of his legs and that it was unlikely he would survive a double amputation. An operation was no longer a viable option. He told the man that he would receive palliative care and was likely to die within weeks.
31. The man had consistently complained of leg pain for a number of years and his mobility had declined significantly. The clinical reviewer concluded that the man's symptoms of leg cramps, together with his history of a stroke and smoking should have warranted some consideration of a referral to a vascular consultant and a formal examination of his peripheral vascular system at an earlier stage. It appears from the records available that the man was referred to the Doncaster Royal Infirmary and had had a CT scan. The man had reported this in reception when he arrived in August 2012 and told the physiotherapist this on 2 December. It is not clear who organised this, but the clinical reviewer considered that this would have been ordered by a hospital specialist rather than a GP. Had staff requested the man's community health records, it is likely that a clearer picture of his vascular disease would have emerged and his treatment managed accordingly.
32. The man had been unwell on 8 and 10 December, yet healthcare staff appear to have been slow to respond to the concerns of wing staff. On 10 December, it took some time for the man to be seen by a nurse and then a doctor. The GP suspected that the man might have had a stroke, yet even

then it took another hour and 20 minutes for the man to be taken to hospital. Although it turned out that the man had not had a stroke, and there is no evidence that the delay in getting to hospital affected the outcome for him, we consider that, with his symptoms, he should have been taken to hospital quickly. National Institute for Health and Care Excellence (NICE) guidelines make it clear that there should be no delay in admitting patients with a suspected stroke directly to specialist stroke units. The clinical reviewer also considered that healthcare staff did not complete the man's medical record fully enough or in line with current national standards and noted some inconsistencies between records on 10 December. We make the following recommendations:

**The Head of Healthcare should ensure that community records of newly arrived prisoners are requested and that prisoners with existing hospital appointments are taken to their appointments or have them rebooked.**

**The Head of Healthcare should ensure that staff adhere to NICE guidelines for the diagnosis and management of peripheral arterial disease and ensure that prisoners presenting with symptoms are assessed and appropriately referred**

**The Head of Healthcare should ensure that nurses attend quickly to assess prisoners when wing staff have serious concerns about their wellbeing and that prisoners with symptoms of a stroke or other serious conditions are taken to hospital without delay**

**The Head of Healthcare should ensure that healthcare staff keep comprehensive records in line with the General Medical Council and Nursing and Midwifery Council's guidance on record keeping**

### **The man's medical treatment**

33. After his diagnosis, all of the man's treatment and care was managed by the hospital which is outside the remit of this investigation. On 12 December, after his consultation with the consultant and terminal diagnosis, a palliative care nurse saw the man to discuss and plan for his end of life care. The next day, the hospital informed prison healthcare staff that the man was no longer fit for surgery and would be given palliative care only. The consultant confirmed that the man's life expectancy was likely to be measured in days or weeks.
34. On 13 December, the man was placed on the hospital end of life pathway. He died on 20 December.
35. A post-mortem was not carried out. The Coroner gave the cause of death as multi-organ failure due to acute abdominal aortic thrombosis.

### **The man's location**

36. The man lived in a ground floor single cell at Doncaster, where he remained until his admission to hospital on 10 December 2013. His mobility deteriorated significantly from October 2013 and, from November, he spent most of his time in his cell. He was allocated a prisoner carer who helped him by collecting meals and medication and general daily tasks. The man was given a wheelchair and other equipment in his cell to assist with his personal care.
37. After his terminal diagnosis, the man remained in hospital. Hospital staff discussed the possibility of moving to a hospice with the man, but he preferred to stay in hospital. We are satisfied that the man was appropriately located during his illness.

### **Restraints, security and escort assessment**

38. Prisons have a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.
39. The unit manager carried out a risk assessment before the man was taken to hospital on 10 December. He identified the man as a very high risk to children and a risk of escape. The medical information section noted there were no medical objections to the use of restraints and no health conditions likely to influence the level of restraint. The partially completed supporting healthcare risk assessment by a healthcare administrator, noted that the man's medical condition did not restrict his ability to escape. He was restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and accompanied by two officers. Taking into account the man's medical condition, his frailty and extremely poor mobility it is difficult to see how this assessment of risk could be accurate. Objections to the use of restraints is not what the court judgement requires and it does not appear that there was an appropriate clinical contribution to the assessment which considered how his health and mobility impacted on his ability to escape.
40. While in hospital the man's condition worsened rapidly. Prison and healthcare staff were aware of the man's deterioration but this did not trigger a review of the risk assessment, despite daily visits from prison managers. Prison Service guidance after the court judgment requires that "the level of restraint necessary during a prisoner's stay at hospital must be assessed separately

from the level of restraint required for the escort to hospital. The risk assessment must be kept under regular review to take account of the prisoner's changing clinical condition, treatment being received and any input from healthcare professionals". Despite this, the man's risk was not reviewed and he remained restrained by an escort chain until 15 December until the risk assessment was reviewed and the restraints were removed. The prison escort was then reduced to one officer. We make the following recommendation:

**The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time**

### **Liaison with the man's family**

41. The man had not been in contact with his family for a number of years. On 12 December, the man was given a life expectancy of a matter of weeks. Two days later he asked if someone could contact his son and inform him of his condition. A unit manager tried to contact the man's son by telephone a number of times and left messages, but did not receive a response. A police officer from the public protection unit involved in the man's management, eventually established contact and the man's son visited him on 18 December.
42. The man died on 20 December. Due to annual leave a trained prison family liaison officer was not available and the Director's personal assistant, took on this role until a trained family liaison officer was appointed on 31 December. The prison offered financial assistance towards the funeral in line with national guidance. The man's funeral took place on 20 January 2014.
43. We are satisfied that the prison provided appropriate support in this case and the prison made good efforts to contact the man's son. However, we consider that family liaison is a specialised role which usually requires a trained officer. Prisons need to have appropriate family liaison cover, including at peak holiday periods. We make the following recommendation:

**The Director should ensure that trained family liaison officers are available at all times to support deceased prisoners' families.**

### **Compassionate release**

44. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
45. On 12 December, the man was told he had only a short time left to live. The prison was informed of this on 13 December. On 16 December, the man said he wanted to be considered for release on compassionate grounds and an

application for compassionate release was made. Because he died very shortly afterwards, a decision had not been made before the man's death on 20 December.

46. We consider that it would have been best practice for the prison to have discussed the possibility of compassionate release with the man on 13 December, when they were informed of his prognosis, or shortly after. However, this would still have allowed very little time for an application to be considered. Records show that there were concerns about the man's proposed release address, so it is unlikely in any event that compassionate release would have been granted.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that community records of newly arrived prisoners are requested and that prisoners with existing hospital appointments are taken to their appointments or have them rebooked.
2. The Head of Healthcare should ensure that staff adhere to NICE guidelines for the diagnosis and management of peripheral arterial disease and ensure that prisoners presenting with symptoms are assessed and appropriately referred.
3. The Head of Healthcare should ensure that nurses attend quickly to assess prisoners when wing staff have serious concerns about their wellbeing and that prisoners with symptoms of a stroke or other serious conditions are taken to hospital without delay.
4. The Head of Healthcare should ensure that healthcare staff keep comprehensive records in line with the General Medical Council and Nursing and Midwifery Council's guidance on record keeping.
5. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.
6. The Director should ensure that trained family liaison officers are available at all times to support deceased prisoners' families.

## ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible
1.	The Head of Healthcare should ensure that community records of newly arrived prisoners are requested and that prisoners with existing hospital appointments are taken to their appointments or have them rebooked.	Accepted	<p>All prisoners entering HMP Doncaster are asked to sign a consent form to enable information to be requested from external agencies. This process is completed for all new patients. Community records will be requested for all prisoners who have consented.</p> <p>There is a new process for monitoring external appointments, any appointments that are cancelled are automatically rearranged, and this is tracked electronically.</p>	Completed Head of Healthcare
2.	The Head of Healthcare should ensure that staff adhere to NICE guidelines for the diagnosis and management of peripheral arterial disease and ensure that prisoners presenting with symptoms are assessed and appropriately referred.	Accepted	<p>All patients entering HMP Doncaster are identified through the health screen process. Once identified, the patient's condition is recorded using the Read Code function now available on the SystmOne electronic medical record. This system enables clinicians to identify any patient requiring specific nursing interventions for chronic conditions.</p> <p>Patients with chronic/complex medical needs are placed on the Chronic Disease Register. Care plans are generated at this point with monthly reviews scheduled on the appointments ledger. This system ensures all patients are monitored on a monthly basis and care plans will be generated at this point with monthly reviews scheduled on the appointments ledger.</p>	Completed Head of Healthcare
3.	The Head of Healthcare should ensure that nurses attend quickly to assess prisoners when wing staff have serious concerns about their wellbeing and	Accepted	<p>Nurses have a duty to respond to concerns from wing staff at all times. If Custodial partners are concerned, they alert medical staff via Radio using the medical response call signs, Code Blue and Code Red.</p> <p>Any patients presenting with serious condition that cannot be</p>	Completed Head of Healthcare

	that prisoners with symptoms of a stroke or other serious conditions are taken to hospital without delay.		safely managed within the secure environment are discharged to Hospital without delay.  The recent introduction of the Emergency Care Practitioner Service provides additional expertise and support to the existing clinical services for any complex/chronic clinical case.	
4.	The Head of Healthcare should ensure that healthcare staff keep comprehensive records in line with the General Medical Council and Nursing and Midwifery Council's guidance on record keeping.	Accepted	Record keeping audits are completed annually and action plans formulated as a response to audit outcomes.  All staff are fully competent with Information Governance and receive refresher training on an annual basis as part of their mandatory training.  All staff are governed by the Nursing and Midwifery Council Guidelines for Record Keeping. Any omissions in practice are managed through Nottinghamshire Healthcare NHS Trust Conduct Policy and Procedure.	Completed Head of Healthcare
5.	The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.	Accepted	The Head of Security has reviewed the process of risk assessments for prisoners taken to hospital, and ensures that they are appropriate, dynamic, and are reviewed periodically to reflect the needs of the individual.	Completed Head of Security
6.	The Director should ensure that trained family liaison officers are available at all times to support deceased prisoners' families.	Accepted	The number of trained family liaison officers at HMP Doncaster has increased from three to four members of staff, and efforts continue to recruit and train further family liaison officers. In addition to this, local contingencies now reflect that in the event that there is a difficulty in accessing this resource, then the wider resource of trained family liaison officers within the Serco Custodial group will be called upon to ensure that trained family liaison officers are available at all times to support deceased prisoners' families.	Completed Security / Safer Custody