

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Swaleside in 2007**

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

May 2008

This is the report of my investigation into the death of a prisoner at HMP Swaleside on 20 May 2007. The man was found in his cell with a plastic bag over his head. At the time of his death the man was serving a life sentence. He was 42 years old.

I would like to add my personal condolences to those already expressed to the man's family by one of my family liaison officers.

The investigation into the man's death was undertaken by one of my investigators. I would like to thank the Governor of HMP Swaleside and his staff for their participation. A doctor from the Eastern and Coastal Kent Primary Care Trust has undertaken a review of the man's clinical care whilst in custody and I also thank him for his assistance.

The man had been suffering from jaundice and stomach pain, due to an enlarged liver, for many months. Confusion over his diagnosis, the missing of a vital hospital appointment and continued deterioration in his health led to his eventual admission to hospital as an emergency. The man was subsequently diagnosed with cancer of the pancreas and underwent major surgery. He was receiving a course of chemotherapy treatment at the time of his death.

The man spent most of his time in custody either in the prison healthcare centre or in hospital. He had been seriously ill for over a year, and felt that he was not receiving the medical attention due to him. He initiated a claim of clinical negligence against the Prison Service and, in letters found after his death, asked that his actions be viewed as a form of euthanasia.

The clinical reviewer has identified a number of significant failings in the medical care given to the man. As a consequence of the clinical review and my own investigation, I make seven recommendations.

Stephen Shaw
Prisons and Probation Ombudsman

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SUMMARY

The man who is the subject of this investigation was 42 years old when he died on 20 May 2007 at HMP Swaleside.

The man had been sentenced to life imprisonment at Winchester Crown Court on 16 September 2004. When first received into prison custody, staff noted his history of multiple drug and alcohol abuse and that his father had committed suicide. The man subsequently complained of severe itching.

Upon the man's transfer to Swaleside on 16 March 2005, the prison's medical officer recorded that the man continued to suffer from itching, was jaundiced and that his liver was enlarged. In April, the man underwent a number of blood tests and was referred to a consultant at the Medway Maritime Hospital. On 29 April, the man had an ultrasound and although his liver and pancreas appeared to be normal, further investigations were recommended.

On 9 June, the man was seen by a specialist registrar. The registrar observed that the man's liver was slightly enlarged and he diagnosed intrahepatic cholestasis or virus related hepatitis. The registrar recorded that he would discuss the man's case with his consultant and that the man would be reviewed in three months.

The man reported sick at Swaleside on 5 August 2005. Staff recorded that he was jaundiced and was awaiting a further hospital appointment. In a witness statement written before his death, the man said that he reported sick regularly between June 2005 and February 2006. He said that on each occasion he was told by staff that there was nothing that could be done for him.

In February 2006, the man described his condition as becoming visibly worse. Staff took further blood tests and he was told by the prison's medical officer that his condition seemed to be improving.

On 1 March, a member of healthcare staff contacted the hospital consultant in order to establish the date for the man's three month follow up appointment. Throughout March and April, the man's condition continued to deteriorate and concerns for his condition were recorded in his medical record.

The man saw the medical officer again on 18 April. The medical officer recorded that the man was still suffering, that his liver remained enlarged and that his hospital appointment was to be pursued.

On 10 May, it was confirmed that the man was to attend a CT scan on 22 May at the Medway Maritime Hospital. The man's appointment was logged in the prison healthcare centre's appointments book. An entry next to the appointment emphasised that the man must attend the appointment and that it was not to be cancelled. However, on 22 May, the man did not attend for the scan as scheduled.

Healthcare staff contacted the Medway Maritime Hospital on 25 May, enquiring if another appointment could be made. They were informed that a decision could not be made until the hospital's consultant returned to work on 5 June.

The man's parents wrote to the Governor of Swaleside on 27 May, asking why the appointment on 22 May had been cancelled. On three occasions in June 2006, the man reported sick at the prison, the medical officer noting that he was still awaiting a CT scan.

On 5 June, staff at Swaleside were told that the consultant had still not reviewed the man's case. However, on 7 June staff were advised that a request for a new CT scan appointment had been made.

On 27 June, the man was still awaiting an appointment for his CT scan. Staff were advised by the Medway Maritime Hospital that the waiting time for a CT scan was 16 to 20 weeks. Later that day the prison medical officer wrote to the hospital consultant requesting an urgent CT scan appointment.

The man reported sick again on 4 July, and was seen by a locum medical officer who arranged for his emergency admission to hospital. The man was diagnosed as suffering from cancer of the pancreas, remaining in hospital for the next two months. On 11 September, he was admitted to King's College Hospital in London for exploratory tests.

On 19 October, The man underwent surgery at King's College Hospital which involved the removal of his pancreas, gallbladder and duodenum. The man spent ten days in intensive care at the hospital before being transferred back to the Medway Maritime Hospital on 14 November.

Towards the end of November, the man's condition worsened and consideration was given to early release from prison on compassionate grounds. However, he improved and it was decided that he would start chemotherapy in January 2007 at Maidstone Hospital.

The man returned to Swaleside from Medway Maritime Hospital on 21 December. His condition remained stable although there was some deterioration as a consequence of his chemotherapy treatment.

On 18 May 2007, a missed hospital appointment was rescheduled to take place on 21 May. However, on the morning of Sunday 20 May, the man was found dead in his cell, having apparently taken his own life.

My report is critical of the man's clinical care. However, the circumstances of his death could not reasonably have been predicted by prison staff.

THE INVESTIGATION PROCESS

1. My investigator reviewed all relevant prison records relating to the man. These included his core prison record, medical records, statements and other relevant documentation. My investigator also visited Swaleside to interview a number of staff, interviewing a number of them with the clinical reviewer. However, the medical officers who had treated the man were not interviewed. One was unavailable and the other no longer works at the prison.
2. At the time of his death, the man was being represented by a firm of solicitors, with regard to a potential clinical negligence claim against medical staff at the prison. The claim centred on an alleged delay in diagnosis and treatment of his pancreatic cancer. The man signed a witness statement on 6 May 2007 in support of his claim against the Prison Service. My investigator has had access to this statement and reference has been made to it in my report.
3. Eastern and Coastal Kent Primary Care Trust was commissioned to undertake a clinical review of the care afforded to the man. They identified a doctor to carry out a clinical review of the man's clinical care. I am grateful to the clinical reviewer for undertaking the review in a most timely manner, and can confirm that he was provided with a copy of the man's witness statement in addition to his medical records. Early disclosure of the clinical reviewer's report was made to the Eastern and Coastal Kent PCT, because of the nature of the clinical reviewer's findings. The clinical review was also disclosed to the Governor of Swaleside at this time (September 2007).
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. A copy of this report will be sent to the Coroner to assist his enquiries into the man's death.
5. One of my family liaison officers contacted the man's family. She and my investigator met with his mother and stepfather to discuss the purpose and scope of the investigation, and to give them the opportunity to raise any concerns they had. The man's parents raised a number of concerns and observations including:
 - Their understanding that their son had not been seen by "anyone in particular" for ten days following an operation at the Medway Hospital.
 - Their son appeared bruised, as if he had been "beaten up", during a visit they made to him in May 2007.
 - Their son had been prescribed steroids in the weeks leading to his death.
6. The man's parents were also concerned that he had been given 100 paracetamol tablets by the prison's medical officer. My investigator found evidence to suggest the man was prescribed paracetamol and other painkillers before his admission to hospital in July 2006, but these were administered in accordance with prison/medical procedure. My investigator was unable to establish whether or not the man made an application for a visiting order prior to his death, or if he had 'practised' an attempt on his life in the days immediately

before 20 May 2007.

7. I hope that my report addresses these issues and answers the questions that the man's parents raised with my family liaison officer and investigator. A subsequent meeting to discuss the draft report also took place and my Investigator was able to clarify a number of points the man's parents had raised, having seen the draft report. The man's parents said that they had been hurt by a couple of inappropriate comments made by staff whilst their son was on bed watch. However, on the whole they said that they had been very pleased with how staff had conducted themselves and the way they had treated their son when guarding him in hospital.

HMP SWALESIDE

8. Swaleside opened in 1988 as a category B training prison. It accepts prisoners who are serving a sentence of four years or more, or who have at least 18 months left to serve. Swaleside has an active regime with a focus on resettlement. The prison provides a range of accredited offending behaviour courses and other non-accredited courses, including victim awareness and anger management.
9. Provision of healthcare within the prison is the responsibility of Eastern and Coastal Kent Primary Care Trust. The healthcare centre employs a full-time doctor and 11 registered nurses, both registered general nurses and registered mental nurses, who provide 24-hour nursing services. The centre has 15 in-patient beds. Nursing staff run clinics for diabetes and asthma, in addition to a Well Man clinic. Medication is administered on a weekly or monthly basis to those prisoners who have been risk assessed as suitable to hold it in their own possession. It is administered on a daily basis to other prisoners.

KEY FINDINGS

10. The man who is the subject of this investigation was received at HMP Winchester on remand on 20 July 2004. On 16 September 2004, he was sentenced to life imprisonment with a minimum term of six years and ten months. During the first six months of his sentence, the man was described in his prison wing history sheets as polite and well mannered. He was given the trusted position of being a wing cleaner.
11. On reception, the man was seen by healthcare staff at Winchester. The man's multiple drug use and high alcohol intake were recorded and it was noted that his father had committed suicide. The man's Continuous Medical Record (CMR) notes that he complained of "occasional abdominal pain". On a Nursing Evaluation Record, dated 21 July, it was recorded that he had been drinking one litre of vodka on a daily basis.
12. In the witness statement to which I have referred, the man says that in February 2005 he reported sick to the prison doctor, complaining of severe itching and depression. However, there is no entry in the man's CMR that this was the case. The clinical reviewer states that on 8 March, the man was seen in healthcare, complaining of generalised itching. He was prescribed antihistamine and antidepressant medication. The clinical reviewer observes, "No investigations were carried out and no specific diagnosis was apparently made."
13. The man was transferred to Swaleside on 16 March 2005. It was recorded during reception that he was suffering from itching and depression. On 22 March, the man attended sick parade. He was seen by the prison's medical officer. The medical officer noted that the man was jaundiced and that his liver was enlarged. An abdominal ultrasound scan was requested. (The ultrasound was completed on 28 March.)
14. On 11 April, the man underwent a number of blood tests. The clinical reviewer notes that a referral letter, dated 13 April, was written by the prison medical officer to the Consultant Physician and Gastroenterologist at the Medway Maritime Hospital. The letter requested an "early appointment" in order to investigate, diagnose and treat the man's jaundice and enlarged liver.
15. In his witness statement, the man says that the itching:

"... became absolutely unbearable – to the point that I was scratching so much that I drew blood. As a result of the distress, I lost sleep. None of the anti-allergy pills appeared to work, and my jaundice became noticeable and my liver started to show signs of swelling."
16. In his report the clinical reviewer says that:

"On 11 April 2005, no ultrasound appointment having been received by Healthcare at HMP Swaleside, contact was made with Sheppey Hospital X-ray Department. Healthcare was advised that the ultrasound referral form of 22 March 2005 had been passed to Medway Hospital and that the waiting

time was 'about two months on average'."

The man had an ultrasound scan on 29 April. His liver and pancreas were described as normal but a polyp in the gall bladder was highlighted and further investigation was recommended.

17. The clinical reviewer notes that on 9 June 2005 the man:

"... was seen at Medway Maritime Hospital by a Specialist Registrar to another Consultant Physician and Gastroenterologist in response to the referral by Prison Healthcare."

"Although the specialist registrar did not have access to the man's blood tests he was able to review his ultrasound scan." The clinical reviewer said, "The Registrar found on examination a 'slightly enlarged liver'. His diagnostic 'impression' was of 'intrahepatic cholestasis' or 'virus related hepatitis'."

"The registrar stated that he would discuss the man's case with his consultant, and as a consequence the man would be reviewed in three months time."

However, the clinical reviewer could "... find no documentation relating to any discussions that took place between the registrar and the consultant..."

18. An illegible entry of 16 June, thought to be by the prison medical officer, suggests that the man had gall stones and was jaundiced. In the prison medical officer's entry of 17 June, which I believe has been incorrectly entered as 17 May, he records that the man, "Has seen gastroenterologist last week, await letter..."

19. On 5 August, the man again reported as sick. Healthcare staff at Swaleside recorded that he was jaundiced and awaiting a further hospital appointment. On 31 August, the man did not attend healthcare as expected, but no reason for his non-attendance was recorded by staff.

20. In his witness statement the man writes that he reported sick regularly between June 2005 and February 2006. He adds that, "on the rare occasions that the prison medical officer actually examined me, he constantly told me that there was nothing that he could do for me." My investigator has established that, other than the dates already mentioned above, there is no record of the man being seen by either prison doctors or medical staff during this period.

21. The man writes that in February 2006 his condition changed dramatically. He says his "liver was severely swollen and I started to get severe pain in my stomach and bowel." The man describes himself as being weak and having difficulty in functioning, saying that his condition became visibly worse. He says that during this time a number of blood tests were taken, all of which came back negative. The man claims that during this period the prison medical officer, "continued to assure me that my condition seemed to be getting better."

22. On 28 February 2006, the man was seen by the prison medical officer. He recorded that the man was still waiting to see the gastroenterologist and that his liver was more enlarged. The clinical reviewer notes that further blood tests were taken and the prison medical officer asked healthcare staff to determine when the man's follow up appointment was.
23. On 1 March, the healthcare assistant responsible for medical appointments at Swaleside e-mailed the consultant physician and gastroenterologist's secretary to establish when the three month follow up appointment, made as a consequence of the man's consultation on 9 June 2005, would take place. The consultant's secretary confirmed that the man's liver test functions looked normal. She said that she had passed the man's notes to the consultant and would reply further when the consultant had made a decision.
24. The man was again seen in the healthcare centre at Swaleside complaining of stomach cramps on 6 March. The clinical reviewer says that his "... condition continued to deteriorate and he was seen on several occasions in healthcare where growing concern for his clinical condition was recorded."
25. On 29 March, the man spoke with his personal officer about the pain and discomfort he was suffering. The man's personal officer recorded in his wing history sheets that he was experiencing problems with healthcare, in particular his diagnosis and treatment. The man's personal officer told my investigators that the man believed staff were not giving him clear answers to his questions, and that this frustrated him.
26. The personal officer recorded on 10 April, that the man had failed to attend his art class. On 15 April, she noted his discomfort and that he was putting on a brave face, his medication only offering temporary relief. On 5 May, she recorded that the man was still suffering and that over the following months there was a gradual deterioration in his health.
27. The man was seen again by the prison medical officer on 18 April, who recorded on the man's CMR that he was awaiting a gastroenterology appointment, was suffering from lower abdominal pain and enlarged liver, and noted that the man's hospital appointment should be chased up. On 25 April, the man attended sick parade where he was told of a number of negative blood test results. Again it was noted that he was "awaiting ongoing appointment with gastroenterology."
28. On 10 May, a further e-mail was sent by the prison's healthcare assistant to the consultant's secretary enquiring about the man's follow up appointment. That afternoon, an appointment was made for the man to attend a CT Scan on 22 May. The man's appointment was logged in the healthcare appointments book. An asterisk next to the appointment said, "must go, do not cancel", and the prison medical officer wrote underneath, "Do not cancel under any circumstances."
29. The man attended sick parade on 16 May. The medical officer recorded that the man continued to suffer from liver pain but that his prescribed pain killers

alleviated his discomfort.

30. The man did not attend the CT scan scheduled for 22 May. The clinical reviewer notes that no reason was given as to why the man was unable to attend. He says that the scan was simply recorded as having to be “rescheduled”.
31. The consultant’s secretary contacted the prison healthcare assistant on 23 May. She enquired why the man had not attended his CT scan the previous day. The healthcare assistant said she was unsure why he did not attend, but asked that another appointment be made. The consultant’s secretary replied that she would have to check with the consultant first.
32. On 25 May, the man’s personal officer recorded on his wing history sheets that he had told her that his hospital appointment had been cancelled until further notice. That day the man submitted a Form Comp 1 (a prisoner’s complaint form). He said that he had been suffering from a liver complaint, and that the last time he had seen a specialist was in June 2005 when he was told that he was to return to hospital within three months for further treatment. The man explained that the prison doctor had told him that he would be attending an appointment, but that this had now been cancelled.
33. The prison healthcare assistant contacted the consultant’s secretary on the afternoon of 25 May, enquiring if another appointment had been made. The secretary confirmed that no decision had been taken and that the issue would have to wait until the consultant’s return on 5 June.
34. The man’s parents wrote to the Governor of Swaleside on 27 May. They enclosed a letter which they had intended to send a few weeks previously (they had not done so as the man had been told that he was to have a scan on 22 May and that it was not to be cancelled). The letter advised that the man had contacted them to say that the scan never took place.
35. The prison medical officer recorded on 26 May that the man had reported sick and that his CT scan had been rescheduled. The man reported sick on three occasions between 2 June and 20 June. On the two most recent dates it was noted that he was still awaiting a CT scan.
36. On 2 June, an unidentified person noted in the hospital appointments book, with regard to the man’s missed CT scan on 22 May, “did not go, why?”
37. The prison healthcare assistant contacted the consultant’s secretary again on 5 June. She said that, in the light of correspondence from the man’s family the prison required a firm date as to when a new appointment would be made. The secretary responded on 6 June advising that the consultant had not yet reviewed the man’s case. On 7 June, she reported that a request for an appointment had now been made.
38. On 8 June, the healthcare manager at Swaleside responded to the letter from the man’s parents of 27 May. He said that the man had been referred to the Gastroenterology department at the Medway Maritime Hospital. He said that the

appointment for 22 May had unfortunately been missed and that Swaleside had been in contact with the hospital to rearrange. The healthcare manager at Swaleside responded to the man's own complaint form on 8 June 2006 saying, "I apologise for the delay in your treatment. I have spoken with the consultant's secretary to reschedule your scan and am awaiting an appropriate date."

39. The man spoke with his personal officer on 11 June. She recorded that he did not look well and had asked his family to contact healthcare on his behalf with regard to his rescheduled appointment. The personal officer noted that the man had informed his solicitor that he was becoming too ill to eat. On 18 June, she recorded that his condition was worsening, that healthcare were aware, but that still no new appointment had been made. On 24 June, it was recorded that the man had attended art class in order to take his mind off his pain.
40. The prison medical officer noted that the man was still awaiting his CT Scan on 27 June. The prison healthcare assistant spoke to the scanning department at Medway Maritime Hospital and was told that the waiting time for a CT scan was 16 to 20 weeks. That day, the medical officer wrote a letter to the consultant requesting another urgent CT scan appointment. The letter explained that the missed scan appointment on 22 May was due to staff shortages.
41. On 3 July, the man's personal officer recorded that he was visited by his parents and that his health continued to deteriorate.
42. The man attended healthcare for a repeat prescription and was seen by the locum medical officer on 4 July. The clinical reviewer notes that the man had become sufficiently unwell for the locum medical officer to arrange for his emergency admission to Medway Maritime Hospital via the accident and emergency department.
43. The clinical reviewer says that:

"Following admission and investigation at Medway Hospital, the man was diagnosed as having cancer of the pancreas affecting the opening of the pancreatic duct into the duodenum. A biliary stent was inserted endoscopically to attempt to keep the pancreatic duct patent and to slow the rate of progression of the jaundice."
44. A case conference on 29 August held at the Medway Maritime Hospital reported that the man's tumour appeared to have grown. An approach was made to King's College Hospital to establish whether the man's condition was operable.
45. On 31 August, the man's medical record said that, "He is not for further active treatment and will be referred for palliative care." However, on 8 September, medical staff at the Medway Maritime Hospital expressed cautious optimism that the man could proceed with active intervention at King's College Hospital. The man's medical records note that, as a consequence, an application for early release on compassionate grounds would be suspended.

46. The man was admitted to King's College Hospital on 11 September for exploratory tests. He returned to Swaleside on 9 October and was then re-admitted to King's on 18 October. On 19 October, the man underwent surgery which involved the "... removal of the pancreas, gallbladder, duodenum and associated lymph glands (whipple's procedure)." The man spent ten days in the liver intensive care unit at the hospital. On 30 October, he was moved to a normal ward where prisoner restraints were reapplied.
47. The man was transferred back to the Medway Maritime Hospital on 3 November. On 13 November, the prison medical officer attempted to visit him in hospital. However, he was unable to do so having been told by staff that the man was either attending a scan or had gone for a walk.
48. On 14 November, a case conference was held at Medway Maritime Hospital. It was recorded that the man was to be considered for chemotherapy and a referral to the palliative care team would be made.
49. Entries in the man's CMR on 23 and 24 November indicate that consideration was being given to moving him to a hospice. Staff also recorded that his condition was deteriorating. A doctor from the Medway Hospital advised that it might be necessary for staff to make preparations for his early release on compassionate grounds. The clinical reviewer notes that the man, "... subsequently received palliative chemotherapy and regular morphine based analgesia assisted by regular help and advice from the Wisdom Hospice team and hospital based dieticians."
50. An oncology appointment at Maidstone Hospital was cancelled by hospital staff, as it was reported that the man had been diagnosed with Clostridium Difficile (a hospital infection more commonly known as C Dif).
51. A special registrar and consultant medical oncologist at Maidstone Hospital, wrote to the medical officer at Swaleside on 11 December. She reported that the man was still an in-patient, was currently recovering from C Dif and was not well enough to be discharged back to prison. The man's appetite was improving but he was often physically and mentally exhausted by late afternoon. The consultant oncologist added that the man would be seen three weeks later to establish whether he was sufficiently fit to start chemotherapy.
52. On 15 December, the man's Continuous Clinical Record (CCR) states, "Visit by Gov – SMO. Consultant on leave, review Monday." However, the man's bed watch sheets say that only the medical officer at Swaleside visited him at the Medway Hospital that day.
53. The man's progress was discussed at a case conference at the Medway Hospital on 18 December. A hospital consultant was present. As a consequence of the meeting, it was recorded on the man's CMR that he could return to Swaleside if the prison was able to meet the strict dietary needs enabling him to gain strength in order to commence chemotherapy in the New Year. The man returned to the healthcare centre at Swaleside on 21 December. In his clinical review, the clinical reviewer notes that the hospital consultant confirmed "... that such a

transfer was not prejudicial to the man's well being, nor to the continuation of his chemotherapy treatment."

54. In his witness statement, the man expresses concern that he was discharged from hospital shortly before Christmas on the Governor's personal intervention. The man alleges that he was moved back to Swaleside because of the staffing problems over the Christmas period that his admittance in hospital would cause. However, my investigator has found no evidence to substantiate the man's claim that he was moved back to Swaleside because of staffing difficulties. It was noted during a case conference on 12 December at the Medway Maritime Hospital that he was, "to be kept in hospital until after his first chemotherapy, due to start in three weeks time."
55. On 19 December, a dietician at St Bartholomew's Hospital wrote to the prison healthcare manager, outlining the man's dietary requirements. She stressed that it was imperative he maintain and gain weight so that he could receive his chemotherapy.
56. The healthcare appointments book reveals that an outpatient appointment for 21 December was rescheduled by the Medway Maritime Hospital to 4 January 2007. The man attended this appointment. However, bed watch sheets state that he was to be discharged the following day (21 December). An officer noted in the bed watch sheet that:

"Contacted control, Ops, Healthcare, Seg, trying to locate letter from Kings College to cancel appointment for tomorrow. Due to logistics. The man will return to prison tomorrow afternoon. Needs to be discharged from Medway. Mother visiting tomorrow also."

It is also recorded that the appointment for King's College would be changed to 4 January.

57. The clinical reviewer reports that healthcare staff said that the man's general physical condition and mental state remained stable after his transfer back to Swaleside. However, he notes that the man's condition:

"... did however appear to deteriorate to some extent as the cumulative effects of the chemotherapy became apparent. The man apparently developed a bruised appearance which would have been due to the combined effects of his liver disease, chemotherapy, and the steroids prescribed by the oncologist in the management of his malignant disease."

"The man however continued to eat reasonably well, remained ambulant and self caring and prepared some of his own food."

The man's medical record contains a note on 5 January that the prison kitchens had been "... informed, supplements to be re-supplied."

58. On 5 January 2007, the man was seen by the consultant medical oncologist at Maidstone Hospital. She reported to the medical officer on 9 January that it was

hoped to start his chemotherapy treatment within the following two weeks. The man received his first chemotherapy session on 29 January, attending Maidstone for regular chemotherapy appointments until shortly before his death.

59. Throughout the remainder of January and February 2007, six entries were made by nursing staff in the man's continuous medical record. During this period, the man had a blood test and his medical records were copied for his solicitors. The prison received medication from the Wisdom Hospice and the man suffered a bout of diarrhoea for three days.
60. On 25 January, the man underwent a colonoscopy to investigate his on-going abdominal pain. From the end of January to 17 May, nine entries were made by medical staff in his CMR. According to the CMR, the prison's medical officer only saw the man once during this period. Other, poorly completed prison medical records indicate that the man took his medication, attended appointments and, although weak and tired, remained cheerful. He was sleeping a lot but mixing with other prisoners when able to do so.
61. The man had a catheter inserted on 29 January at Maidstone Hospital. In a chemotherapy patient referral letter of 29 January, the medical officer at Swaleside was advised that the man's catheter should be cleaned every seven days.
62. The healthcare appointments book records that an appointment with the dietician at Sheppey Hospital on 21 February was rescheduled for 21 March. No reason is given for the rescheduling.
63. Numerous entries in the man's wing history sheets show that, on returning to Swaleside from hospital in December 2006, he continued to be polite, well mannered and respectful towards staff, causing no problems. However, an entry on 19 May 2007 says, "Remains polite but can become quite upset and assertive re his OSH [outside hospital] appointments."
64. In his clinical review the clinical reviewer notes that:

"In the days prior to his death the man appeared to be relatively comfortable with his analgesia, although occasionally 'irritable'. The man himself however records ongoing severe abdominal pain, and his frustration with what he regarded as inadequate medical supervision."
65. A note on the man's care plans evaluation says that on 20 April he should have attended an outpatient's appointment but that no transport or escort had been arranged. The man was said to be, "very disgruntled as a result" and alternative arrangements were made for the following week. Over the following days, staff made numerous notes that the man was requesting pain relief.
66. On 8 March, the man's CMR recorded that he would be attending for a line flush of his catheter the following day. On 27 April, a note on the record says "PICC catheter flushed with 10mls normal saline assisted by the prison medical officer."

67. In his witness statement, the man alleges that his catheter should have been cleaned weekly at Maidstone Hospital as there was no one at the prison qualified to carry out the procedure. He says that Swaleside had been having problems making appointments to get him to hospital. The man says that on 20 April he was due to see a doctor at Maidstone to have a pre chemotherapy check up, blood tests, and have his catheter cleaned. He alleges that, despite the appointment card being stapled in the healthcare diary, no arrangements were made, and the following week passed without him undergoing chemotherapy. He says that on 26 April he complained to the prison doctor that his line had not been cleaned for 14 days, and was told by the prison medical officer that he was qualified to flush and change the line.
68. The clinical reviewer judges, with regard to the cleaning of the man's catheter that, "Although this procedure should have been carried out weekly, and it had been two weeks since it had previously been done, the procedure was well within the competence of trained nursing or medical staff [at Swaleside]."
69. Although not clearly recorded in the healthcare appointments book, an appointment for the man to attend hospital on 20 April was rescheduled. However, no reason for the rescheduling was given.
70. On 9 May, the prison medical officer prescribed Nystatin for the man's oral thrush. The last entry in the man's continuous medical record was made on 17 May, although this was altered to read 16 May. It said that the man had been seen by a nurse from the Wisdom Hospice and that he might require a course of steroids. These were ordered by the prison medical officer the following day, along with a number of blood tests.
71. The man was due to attend an appointment at Maidstone Hospital on Friday 18 May. However, it is recorded in the appointments book that this was rescheduled for Monday 21 May. An unknown member of staff wrote in the margin of the appointments book, "Appointment rescheduled to 21 May 2007 by a senior officer due to no staff." The man phoned Maidstone hospital that morning in order to confirm whether or not his hospital appointment had been cancelled. The man was told by a member of staff at the hospital that his next chemotherapy appointment was scheduled for 24 May.
72. At 7.04pm that Friday evening the man spoke with his mother. The man's mother said that her son was in a "terrible state" and very angry. The man told his mother about the confusion over his appointments and how he had tried to sort things out that morning by telephoning the hospital directly. He told his mother that the prison did not have enough medication to assist in managing his symptoms, and he expressed concern that his catheter had not been cleaned as required. The man's mother said it was this kind of treatment that made her son believe he was being treated as a second class citizen.
73. At 2.30pm on 19 May, the man spoke with his mother for the second time that weekend. His mother said that he was like a different person. He was calm and peaceful and said everything was "tickety-boo". During their conversation, the man told his mother that he had been informed his cancelled appointment would

now go ahead on Monday 21 May. The man said that he had slept poorly the previous night but had managed to sleep that day. The man and his mother also discussed the medication he was taking and talked briefly about the FA cup final, which was being played that afternoon. The man spoke with his mother once more at 4.54pm when they again briefly discussed the football. The man gave no indication of any intention to harm himself at this time.

74. At about 8.05pm that evening, the night shift nurse arrived in the healthcare centre to begin her shift. She told police that she received a verbal handover from the nurse who had been working the day shift. During the handover, the days shift nurse told the night nurse that the man had requested a sleeping tablet that evening.
75. The night nurse gave the man his medication during her rounds. She said that she noticed he had two bits of tissue rolled up and stuck in each nostril. The man told her that he had a runny nose but felt fine. The night nurse said that the man asked to be given his sleeping tablet at about 11.00pm that evening.
76. In the early hours of 20 May, some time between 12.30am and 1.00am, the night nurse returned to the man's cell and gave him the sleeping tablet he had requested along with other medication. The night nurse said she and the man spoke briefly and joked about things. She said that the man appeared, "Fine [with] no problems. In fact to the point when he actually said I'll see you tomorrow, I said, not if I've won the bloody lottery you won't and we had a laugh about that."
77. The night nurse said that nothing unusual or untoward happened that night. She commenced her early morning check of prisoners at about 6.00am. The night nurse told police that, on looking in the man's cell, she noticed that he was lying on his back, with his head at the opposite direction from usual, his head and shoulders being obscured by his locker. She said that she did not speak with the man nor was she concerned as his pillow had been in that position all week.
78. The day nurse arrived back on duty at about 7.00am to 7.05am the following morning. He was met by the night nurse who provided him with a verbal handover. The night nurse reported that there had been no problems and both nurses proceeded with their prisoner checks.
79. Upon reaching the man's cell, the night nurse became concerned that the man had not moved since she had last seen him. In her police statement, she said that she called out to the man in order to obtain a response but there was none. At 7.10am, the night nurse raised the alarm by calling an emergency code 1. She told staff that she was concerned about the man and was going to enter the cell. The day nurse unlocked the cell door and entered the cell immediately with the night nurse.
80. The day nurse told police that on entering the cell he saw the man lying on his back. The night nurse said that the man had a "... thick clear plastic bag over his head. It was tied round his neck with what looked like a dressing gown belt cord." The night nurse said that the man's right hand was tied to the bed and

she could see straightaway that he was dead.

81. Both nurses checked the man for signs of life. However, the day nurse could find no pulse and the night nurse said the man felt cold to the touch. She said, "I was shocked more than anything and I could see there was no obvious enough signs of life, no signs of breathing, his colour, he was very cold to the touch."
82. In his statement to police, the day nurse said he removed the bag and ligature from around the man's neck and checked for signs of life. There were none. The day nurse noticed that the bag which had been on the man's head contained condensation. The night nurse told my investigators that she believed the day nurse removed the bag from the man's head, but she could not remember precisely what happened.
83. A principal officer had just commenced his shift and was in the operations room, approximately one minute away from the healthcare unit, when the emergency was called on the radio. He said that on his arrival at the man's cell, the day nurse, who was coming out of the cell, told him that the man was lying on his bed with a plastic bag over his head. The principal officer asked the day nurse if there were any signs of life. The day nurse replied that rigor mortis had clearly set in. The principal officer entered the cell and asked both nurses to check for any signs of life and to confirm whether or not CPR should be attempted. Both nurses answered that it was too late to administer CPR. The principal officer said the decision was made to remove the plastic bag and for the cell to be sealed.
84. Another officer also responded to the emergency call, although on arrival in the healthcare centre he did not see the man or enter his cell. My investigator asked the officer what happened after the staff had left the man's cell. He said, "They were describing what condition he was in and were unsure whether to leave him as he was or actually cut the bag and the noose, and all that off him for humanitarian reasons ...". The officer said that staff were not 100 per cent sure what to do. He said that it was only when they had spoken with the head of healthcare that staff returned to the cell to remove the bag from the man's head.
85. A senior officer told my investigators that he attended the healthcare unit on hearing the emergency code being called at about 7.05am. He entered the cell after the principal officer and saw the man lying on the bed with a bag over his head. The senior officer said the day nurse confirmed that rigor mortis had set in and that attempting CPR would not have been effective at this time.
86. The incident log records that between 7.08am and 7.15am the day nurse contacted the head of healthcare on the telephone. The log records that, "On advice from phone call from the head of healthcare the day nurse entered cell and removed ligature and bag from the man's neck and head."
87. The healthcare manager told my investigators that, although he could not be sure of the exact time, he believed that the day nurse phoned him at home at approximately 8.00am. My investigator asked the healthcare manager if he had told staff to re-enter the cell to remove the bag from the man's head. The

healthcare manager said he had not. He said that the day nurse had asked him what he should do with the bag, and he told the day nurse to remove it.

88. Kent Police recovered a number of letters and notes addressed to the man's parents, friends and the medical staff. In a letter to the Governor, the man explained that his actions should be considered as euthanasia and were a choice he had made over a long period of time. The man went on to describe his treatment at Swaleside as: "... appalling, negligent and incompetent". He condemned healthcare staff as useless although some, he said, had tried their best.
89. A governor at Swaleside, was identified as the family liaison officer. She was notified of the man's death at 8.15am whilst at her home on weekend leave. The family liaison officer attended the prison but due to her own domestic commitments, she was not able to break the news of the man's death to his parents. (The prison's other family liaison officer was on leave.) As a consequence, the decision was taken for the police to inform the man's parents of their son's death. Confirmation of this was given by the police at 12.55pm. Soon afterwards, the man's father spoke with the family liaison officer by calling her on her mobile phone.
90. Over the following days, the family liaison officer maintained contact with the man's parents. She was assisted by a principal officer. The man's parents and other members of his family attended a memorial service held at the prison and met with a number of staff and prisoners. The family liaison officer assisted with funeral arrangements and attended the man's funeral on behalf of the Governor. Financial assistance was provided for funeral expenses and I know that this was gratefully received by the man's parents. The man's parents also spoke highly of the support received from the prison after their son's death.
91. A hot debrief took place at 11.50am on 20 May 2007. Although a number of the officers who responded were in attendance, neither of the nurses who discovered the man were present.
92. The clinical reviewer notes that the post mortem findings of 24 May, "revealed no naked eye evidence of re-growth or spread of the pancreatic cancer, the cause of death solely being 'plastic bag suffocation'.

CLINICAL REVIEW

93. The clinical reviewer says that the man's prison medical records were, "poorly kept, unclear and difficult to read". He says that this and the absence of clearly defined care plans and clinical accountability were issues that should be addressed. The clinical reviewer notes that the identity and status of individuals writing in the medical records was often unclear. I agree with the clinical reviewer's observations on this matter and recommend that:

The Healthcare Manager should ensure that all staff adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.

The Healthcare Manager must ensure that audits of the quality and consistency of such records is undertaken in partnership with the PCT on a regular basis.

The Healthcare Manager should remind all staff of the importance of patient personal care plans, ensuring that they are appropriate and adequate to individual need.

94. The clinical reviewer remarks that within a week of the man being transferred from Winchester to Swaleside it was recognised by the medical officer that he had a liver condition requiring investigation. Blood tests and scans were arranged and a referral was made to the consultant physician and gastroenterologist at Medway Maritime Hospital for an appointment. However, the scan of 29 April 2005 did not confirm the initial diagnosis and further investigation was recommended.

95. The clinical reviewer reports that:

"The consultant to who[m] the man had been referred was apparently not available on 9 June 2005 and the 'impressions' reached by the Specialist Registrar, doubtless influenced by the man's history of drug and alcohol abuse, subsequently proved to be incorrect.

"A routine follow-up appointment was to be made for three months. This appointment was never received nor is there evidence in the records provided that the Registrar ever discussed the case with his Consultant.

"No further direct specialist involvement occurred until the man was admitted as a desperately ill man on 4 July 2006, more than 15 months from the time he was first identified as having liver disease."

96. The clinical reviewer concludes that:

"Problems relating to the man's investigation and management arose when he was not seen by the consultant to whom he was referred, but by a more junior

member of staff. The consultant's deputy without, by his own admission, the necessary blood test results came to incorrect conclusions regarding the nature of the man's jaundice and enlarged liver. The suggestion on the scan report that further investigation was indicated was not followed through."

The clinical reviewer recommends that the PCT must:

"... consider the advisability of having a newly referred patient seen by a junior staff member without apparently having the immediate and readily available supervision, support and advice of a more senior colleague. The apparent absence of any recorded discussion between the Registrar and his Consultant regarding a new patient referral and the appropriate clinical management is a further issue that must be addressed."

I do not make a formal recommendation to the Eastern and Coastal Kent Teaching PCT about this issue, but formally draw the clinical reviewer's findings to the attention of the PCT's Chief Executive.

97. The clinical reviewer believes that the man's follow up appointment should have taken place three months after 9 June 2005. No action was taken by staff until 28 February 2006, five months after the three month date at which the man's condition should have been reviewed. It was not until 18 April 2006 that the prison's medical officer asked for the appointment to be chased up, one year after the man was identified as having an enlarged liver.
98. The clinical reviewer points out that the intended three month follow-up appointment was apparently never sent and healthcare staff at Swaleside were frustrated in their attempts to rearrange it. He says, "The failure to provide a timely response by Medway Hospital allowed the man's condition to deteriorate until hospitalisation became essential and urgent ... "
99. The clinical reviewer observes that, "Prison healthcare staff had made several attempts to expedite medical and scan appointments but this proved unsuccessful and a vital scan appointment was missed because of staff shortages in the prison."
100. It was not apparent who, if anyone, in healthcare at Swaleside was ultimately responsible for recording and ensuring that hospital appointments were kept and that follow-up appointments occurred within the recommended time frame. The clinical reviewer concludes that the healthcare centre at Swaleside must evolve failsafe procedures that ensure prompt access to medical services and that follow-up appointments are kept. He says that healthcare staff must not rely solely on hospital initiated follow-up appointments but should maintain a log to monitor prisoner outpatient movements and requirements. A nominated person should be responsible for this log, checking it on a regular basis and taking action as appropriate. I recommend that:

The Healthcare Manager should initiate a comprehensive review into the procedures surrounding prisoner outpatient appointments, to ensure that in future all prisoner follow-up appointments are kept.

The Governor and Healthcare Manager should ensure that prisoners scheduled to attend hospital appointments do so and that any reason for cancellation must be clearly recorded by a senior member of healthcare staff.

101. I draw to the attention of the PCT's Chief Executive a further recommendation made by the clinical reviewer:

“Medway PCT should consider an investigation into the circumstances surrounding their apparent failure to send the man a follow-up outpatient appointment. The Hospital Administration's failure to respond promptly and appropriately to the requests by Prison Healthcare staff for an outpatient follow-up appointment should be reviewed by Medway PCT. Almost a year passed between the man seeing the Specialist Registrar and an appointment for a CT scan being received.”

102. In the community, doctors are able to enter into telephone discussions with consultants and home visits by consultants can be arranged. Where necessary, acute admissions can be made to a hospital to by-pass administrative problems if a patient's condition warrants it. The clinical reviewer says:

“Whilst the custodial environment makes such action more problematic, it is by no means insurmountable. It is to be regretted that the medical officers at HMP Swaleside having correctly recognised a significant problem in the man did not discuss his condition directly and personally with a consultant, especially when healthcare staff were experiencing difficulty in having the man appropriately followed up and investigated as an outpatient.”

I recommend that the PCT, in conjunction with the medical officers at Swaleside, considers a review of communication with healthcare professionals in the community.

103. The clinical reviewer concludes that the general standards of healthcare provided by staff at Swaleside were satisfactory. He says that, “Once the diagnosis of pancreatic cancer had been made, the man's medical and nursing care were in my opinion, and within the constraints of the custodial situation, satisfactory.”

OTHER ISSUES

104. It is apparent from interviews with prison and healthcare staff that the man's discovery came as a great shock to the nurses who found him. As with so many of my investigations, the recollections of staff may differ. The investigation into the man's death is no exception. Staff have given differing accounts as to when the plastic bag was removed from the man's head. I believe that it was not removed immediately. However, both nurses were sure that the man was clearly dead when they discovered him and that rigor mortis had set in.
105. It would have been preferable and more decent had staff removed the plastic bag from the man's head immediately upon discovering him. However, it would be unfair to criticise staff for not doing so given the situation confronting them. The nurses were sure that he was already dead and the bag was removed shortly after.
106. Neither of the family liaison officers at Swaleside was able to visit the man's parents to break the news of his death. Instead, his parents were informed by a police officer from the local police force. Prison Service Order 2710 (Follow up to Deaths in Custody) is clear that the notification of a prisoner's death to his family or next of kin should be made in person by prison staff and not by the police. Although not mandatory, the guidance sets out good practice. The PSO says that, when the distance is too great, staff should make an effort to contact a local prison in order to break the news and the police should only be contacted as a last resort.
107. Swaleside's own Procedural Document 62, Handling Death in Custody, was last reviewed in 2003. Page 50 of the document states that, "...in the event of a death the prison should inform the nominated next of kin and any other person the prisoner has reasonably requested be informed of the death." The document does not provide guidance, of the kind given in PSO 2710, as to how this might be done. I recommend that:

The Governor should review Swaleside's procedures for breaking the news of a prisoner's death to the next of kin. The guidance published in PSO 2710 should be followed.

108. Although a hot debrief took place during the morning following the man's death, it was unfortunate that neither nurse attended. I appreciate that night staff and others may wish to go home, but those directly involved should be present at the hot debrief if at all possible.
109. In this report, I have criticised aspects of the man's clinical care. However, I do not believe the circumstances of his death could reasonably have been predicted by any member of prison staff.

RECOMMENDATIONS

The Healthcare Manager should ensure that all staff adhere to the guidance on records and record keeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.

Accepted – HMP Swaleside said that staff will be reminded of their responsibility and provided with the relevant guidance from professional bodies e.g. NMC, GMC

The Healthcare Manager must ensure that audits of the quality and consistency of such records is undertaken in partnership with the PCT on a regular basis.

Accepted – HMP Swaleside said that an audit tool will be developed in consultation with the Primary Care Trust to undertake checks on clinical records.

The Healthcare Manager should remind all staff of the importance of patient personal care plans, ensuring that they are appropriate and adequate to individual need.

Accepted – HMP Swaleside said staff would be reminded of the importance of individualised care plans for patients via line briefing, monthly group meeting and Notices to Staff.

The Healthcare Manager should initiate a comprehensive review into the procedures surrounding prisoner outpatient appointments, to ensure that in future all prisoner follow-up appointments are kept.

Accepted – HMP Swaleside said that a Healthcare Principal Officer from HMP Elmley had been asked to review the procedures.

The Governor and Healthcare Manager should ensure that prisoners scheduled to attend hospital appointments do so and that any reason for cancellation must be clearly recorded by a senior member of healthcare staff.

Accepted – HMP Swaleside said that a senior member of healthcare staff will record in the clinical notes the reasons for any cancellations or rescheduling of external hospital appointments.

I recommend that the PCT, in conjunction with the medical officers at Swaleside, considers a review of communication with healthcare professionals in the community.

Accepted – HMP Swaleside said that Liaison with the cluster strategic lead for the Primary Care Trust and the doctor has taken place and they have been advised of the recommendation.

The Governor should review Swaleside's procedures for breaking the news of a prisoner's death to the next of kin. The guidance published in PSO 2710 should be followed.

Accepted – HMP Swaleside now has two managers trained as Family Liaison Officers to ensure that all procedures are fully compliant with appropriate guidelines, instructions and best practice.