PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# Investigation into the circumstances surrounding the death of a man in April 2012 at HMP Winchester

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

## December 2012

This is the report of an investigation into the death of a man. He died in April 2012 in his cell in the healthcare wing of HMP Winchester. He was 70 years old. He died of pneumonia, caused by cancer of the left lung. I offer my condolences to his family.

The investigation was carried out by two investigators. A review of the man's clinical care in custody was carried out by two clinical reviewers on behalf of the local PCT cluster. Winchester co-operated fully with the investigation.

The man was diagnosed with two life threatening conditions in the latter part of 2011. The first, cancer of the lung, might have been diagnosed earlier had NICE guidelines been followed when he complained of a persistent cough. He might also have received further support from healthcare staff at this time. Nevertheless, the clinical review concludes that, due to the aggressive nature of the cancer, an earlier diagnosis would not have made a difference to the final outcome. The second life threatening condition was an abdominal aortic aneurysm (swelling to the main artery in the abdomen). This ruptured in January 2012. The necessary surgical repair and recovery led to a delay of several weeks to his radiotherapy treatment.

Overall, the investigation concludes that the man received very good care and support from healthcare staff at Winchester. It is, however, disappointing that restraints were sometimes unnecessarily used during his inpatient admissions and outpatient appointments. In judging security risks, greater consideration is needed of individual circumstances, particularly in terms of health and mobility, of terminally ill prisoners.

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** **December 2012**

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## SUMMARY

1. The man reported a persistent cough in August and September 2011. He saw prison doctors on four occasions and was prescribed various antibiotics. On 27 October, the man was admitted to hospital when he experienced significant shortness of breath. He remained in hospital for three weeks, during which time he was diagnosed with an abdominal aortic aneurysm (swelling to the main artery of the abdomen, making it more likely to rupture) and probable cancer of the lung. He required further tests to determine the specific type of cancer. He had a biopsy at hospital on 20 December. The results showed that he had an incurable cancer of the lung which had spread to his lymph nodes.

2. The clinical reviewer comments that the man's cancer could have been diagnosed at an earlier stage, as latest guidelines are that he should have been referred for a chest x-ray after a persistent cough of three weeks duration. This would have been in September 2011. However, the clinical reviewer goes on to say that this would not have prevented the final outcome, as the man had an aggressive cancer in a part of the lung that was difficult to treat and diagnose. Nevertheless, we recommend that medical staff at Winchester follow NICE guidelines when treating patients who present with a persistent cough.

3. Following his return from hospital on 17 November 2011, there is no evidence that the man received any healthcare follow up until the results of his biopsy were known on 3 January 2012. While the specific type of cancer was unknown, it was clear during this time that he had received a significant diagnosis. We recommend that prisoners diagnosed with a potentially terminal illness receive appropriate support

4. The man agreed to be treated with radiotherapy, with the aim of controlling his symptoms and preventing the spread of the cancer. Before he could begin treatment, he suffered a ruptured aneurysm and was admitted to hospital in an emergency on 16 January. The man spent most of the next five weeks as an inpatient, during which time his aneurysm was surgically repaired and various complications were dealt with.

5. By his return to Winchester on 22 February, the man was using a wheelchair and was admitted to the healthcare centre inpatients unit. A full time healthcare assistant was employed to help him and he was referred to palliative care specialists at a local hospice. The man was assessed on 12 March by the hospice's consultant in palliative medicine, who concluded that he did not have any specialist palliative care needs at the time.

6. When his condition had stabilised, the man's radiotherapy was rebooked. He had five sessions, the last of which was on 11 April. Towards the end of his week long course, he became very unwell. He deteriorated further and died in the healthcare inpatients unit.

7. Although we have highlighted some areas where clinical practice might improve at Winchester, we agree with the clinical reviewer's conclusion that the man received very good care and support following the results of his biopsy. However, we believe there are lessons that could be learnt from the sometimes inappropriate use of restraints during several of his inpatient admissions and outpatient appointments. Most importantly, we believe that more thought should

be given to assessing a prisoner's individual circumstances, particularly in relation to their health and mobility, when determining the level of restraints.

## THE INVESTIGATION PROCESS

8. On 13 April 2012, two investigators issued notices announcing the investigation to staff and prisoners and invited those who wished to submit information to make themselves known. An official prison visitor (a volunteer who visits a prisoner on a regular basis and speaks to them in confidence) contacted the investigators having seen the notices.

9. The investigators visited Winchester on 16 April. During the visit, they saw the room in the healthcare centre where the man had lived for the last two months of his life. They spoke with the clinical team leader, who knew him well, and a prisoner on the unit with whom he was friends. The investigators also met the acting deputy governor, the prison's family liaison officer and three prisoners who were friends with him when he lived on C wing. They were provided with copies of his prison records, including his medical record.

10. The investigators returned to Winchester on 23 May and interviewed three members of staff. They also met the Governor to provide feedback on the investigation and followed this up in writing. A review of the man's clinical care in custody was undertaken by two clinical reviewers on behalf of the local Primary Care Trust.

11. One of the Ombudsman's family liaison officers telephoned the man's daughter, his nominated next of kin, on 14 May. She explained the purpose of the investigation. The man's daughter said the family had no concerns about the clinical care her father received at Winchester, and described the prison's family liaison officer as "outstanding". The family also spoke of how supportive prison staff were and said the prison's family liaison officer communicated well with them. Liaison with the family is discussed in more detail later in the report.

12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, liaison with his family, his location, whether compassionate release was considered and whether appropriate palliative care was provided.

13. As part of the consultation process the family received the draft report. The man's daughter said her family were happy with the findings and recommendations. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

## HMP WINCHESTER

14. Winchester is a category B local prison, holding up to 707 adult remand and convicted men. (Category B prisoners are those who do not require maximum security conditions but for whom escape needs to be made very difficult.) As a local prison, the majority of prisoners arrive directly from court appearances and the population changes frequently. Many of the prisoners are either held on remand or are serving short custodial sentences.

15. Health services at Winchester are provided by a private company. The healthcare centre contains a 22 bed inpatient unit (mostly for patients with mental health needs plus some with primary care needs) and provides 24 hour nursing cover. Doctors from a local practice provide surgeries daily from Monday to Saturday.

16. HM Chief Inspector of Prisons conducted an unannounced short follow-up inspection of Winchester in September 2011. The Chief Inspector found that health services had improved from the previous inspection, with reduced waiting times to see a prison doctor and a range of clinics. He also reported that local policy was to use the Liverpool end of life pathway although, at the time, this had not been used in practice. The inspection team spoke to prisoners who had recently attended appointments at a hospital across the road from the prison. The prisoners spoke of their embarrassment at being handcuffed at all times, including during treatment and scans. The Chief Inspector recommended that prisoners should have access to hospital appointments and treatment "without undue security restrictions".

17. The prison's Independent Monitoring Board (IMB, a body of unpaid volunteers from the local community whose role is to monitor the prison to see that proper standards of care and decency are maintained) report for 2010-11 commented on improvements made in healthcare during the course of the year, much of which was attributed to the new appointment of a modern matron. The report also deemed end of life care at the prison to be excellent.

18. The man is the fifth of six prisoners at Winchester to die since January 2010. Of the four previous deaths, two were also due to terminal cancer. Our reports into these two deaths reflected well on prison healthcare and found that the men in question received care equal to what they would expect to receive in the community.

## ISSUES

### The diagnosis of the man's terminal illness

19. The man was remanded in custody to HMP Parkhurst on 29 July 2009 and, on 9 October, transferred to Winchester. This was the first time he had been in prison, and he had never previously been convicted of an offence. The man was released on bail on 22 December.

20. Having been convicted of murder on 17 June 2010, the man returned to Winchester. The following day he was sentenced to life imprisonment with a tariff of 11 years. (This meant that the earliest point he could be released from prison was 11 years after sentencing, but that he could be held indefinitely if the Parole Board believed he was still a risk to the public.) The man's tariff was later reduced to nine years on appeal.

21. The man was asthmatic and, at the time of his imprisonment, used an inhaler to control his symptoms. In the year following his return to prison after sentencing, the man was treated for various chest infections and was diagnosed with chronic obstructive pulmonary disease (COPD, a collective term for various lung diseases that affect a patient's breathing). The man lived on C wing at Winchester, where he worked as a wing cleaner (a position for more trusted prisoners which is valued as it allows for more time out of cell).

22. After complaining of a cough, the man was examined by a prison doctor on 1 August 2011. The doctor found crepitations (crackles) in his right lung, and diagnosed a chest infection. He prescribed a course of antibiotics.

23. On 5 September, the man saw another prison doctor and said his cough had returned a week previously and he was now coughing up green phlegm. The doctor also found crepitations in the right lung and prescribed a second course of antibiotics. On 22 September, he saw a third prison doctor and reported a cough and shortness of breath. The man was prescribed a different antibiotic. He saw the doctor again on 28 September and said his cough and shortness of breath were continuing. The doctor diagnosed an exacerbation of his COPD and prescribed additional medication.

24. The man reported no further symptoms to healthcare staff until 23 October, when he again said he was suffering from shortness of breath. An appointment was made with a doctor for 25 October, who diagnosed an exacerbation of COPD. He was prescribed further antibiotics. His shortness of breath got worse during the course of the day, and in the evening he was incontinent of urine. He was offered admission to the healthcare centre inpatients unit, but declined.

25. By 27 October, the man's shortness of breath had increased. He was unable to speak in full sentences and his pulse rate was very high. An ambulance was called and he was admitted to hospital.

26. The man remained in hospital until 17 November. During this admission he underwent various tests and was diagnosed with a probable cancer of the left lung (rather than the right lung, where the signs had been) and an abdominal aortic aneurysm (swelling of the main artery in the abdomen, making it more likely to rupture). However, the man required a further biopsy to determine the specific diagnosis of the type of lung cancer.

27. The biopsy was arranged for 20 December at another hospital. The results showed that the man had cancer of the lung which had spread to his lymph nodes.

28. The clinical reviewer considered the timeliness of his diagnosis, and comments as follows:

> "It is possible that his lung cancer could have been diagnosed a little earlier. He was a smoker who presented on several occasions with a cough and signs of a chest infection … Latest guidelines are that he should have been sent for a chest x-ray after a persistent cough for three weeks … This would have been appropriate at the end of September [2011] when he was prescribed his third course of antibiotics in a month. He had a chest x-ray during his admission at the end of October, which ultimately led to the confirmation of his lung cancer diagnosis. This would not have prevented his subsequent death as he had an aggressive form of the disease in a part of the lung which was both difficult to diagnose and treat."

**The Head of Healthcare should ensure that medical staff follow NICE guidelines when treating patients who present with a persistent cough.**

**Informing the man about his condition and treatment**

29. Before his discharge from hospital on 17 November 2011, the diagnosis of abdominal aortic aneurysm and probable lung cancer were explained to the man by the relevant specialists at the hospital. He was also told that he required a biopsy to determine the detailed diagnosis.

30. Following his biopsy on 20 December, the man returned to hospital on 3 January 2012 for the results. As noted, he was told he had cancer of the lung which had spread to his lymph nodes. The consultant also told him that his cancer could not be cured, but that his symptoms might be controlled or improved through treatment such as chemotherapy.

31. There is no evidence that the man received any healthcare follow up for the remainder of the year following his return to prison from hospital on 17 November. An entry in his medical record indicates that the hospital discharge summary, highlighting the probable cancer and aneurysm, was received by healthcare on the day of his return. Given the information contained in the discharge summary, we would expect an appointment to be made with a prison doctor or nurse to discuss the implications of his diagnosis, and to check his understanding of the condition and the psychological impact it might have had on him.

**The Head of Healthcare should ensure that prisoners diagnosed with a potentially terminal illness receive appropriate support from healthcare staff.**

32. When he received the results of his biopsy on 3 January 2012, there is clear evidence of several members of the healthcare team, including the modern matron, spending significant time with him to talk through the implications of his diagnosis. We agree with the clinical reviewer's conclusion that he received "very good" support following the results of his biopsy.

**The man's medical appointments and treatment**

33. The man returned to hospital on 11 January 2012 to discuss his treatment options with the consultant. A healthcare assistant went with him to provide support and ensure he understood the options presented to him. The consultant explained to the man that he could be treated with a combination of chemotherapy and radiotherapy, just radiotherapy or have no treatment at all. It was reiterated that any treatment would be for symptom control only and would not be curative. The man chose to have radiotherapy only.

34. The consultant responsible for treating his aneurysm chose to wait until after the results of the biopsy were known before deciding whether to operate on the aneurysm. The clinical reviewer comments that this delay was appropriate in the circumstances, given the risks involved.

35. Before any of the planned treatment could take place, the man was admitted as an emergency to hospital on 16 January with a suspected ruptured aneurysm. He was transferred to another hospital, where the aneurysm was surgically repaired. We note the clinical reviewer's comment that the immediate diagnosis of a ruptured aneurysm at Winchester ensured that the man arrived at hospital in a stable enough condition to ensure that surgery could go ahead.

36. The man remained in hospital until 31 January. Ahead of his return to Winchester, there was significant liaison between the modern matron and nursing staff at the hospital to ensure that the prison had the equipment needed. This included a pressure relieving mattress and an oxygen concentrator (a device to deliver oxygen to the patient at higher concentrations).

37. On his return, the man moved into a cell on the healthcare inpatients unit. However, he returned to hospital on the night of 1 February after vomiting and complaining of pain. Investigations that took place in hospital revealed that he had severe inflammation of the oesophagus. This was treated with medication, although his discharge was delayed by breathing difficulties experienced in hospital.

38. The man returned to Winchester on 22 February, where he lived in the healthcare inpatients unit and received nursing care. On 16 March, he had an outpatient appointment at hospital. A chest x-ray was taken at the appointment, which showed that his cancer had spread to other parts of the lung. He was again told that the cancer could not be cured, but that radiotherapy might prevent further damage to the lung. The man agreed to undergo the recommended course of radiotherapy.

39. On 30 March, the man went to hospital for a preliminary appointment ahead of radiotherapy. He returned for radiotherapy sessions on 3, 4, 5, 10 and 11 April. Towards the end of his week of radiotherapy, his health deteriorated rapidly. He reported chest pain, nausea and vomiting and was treated with medication. He deteriorated further and died in the healthcare inpatients facility. The cause of death was recorded as pneumonia, caused by cancer of the left lung.

40. It is unfortunate that the man's planned radiotherapy was delayed due to the ruptured aneurysm he suffered. This meant that his cancer had progressed by the time his condition had stabilised to the extent that radiotherapy could go

ahead. We are satisfied that the man received appropriate treatment following diagnosis and was able to attend all appointments available to him. We agree with the clinical reviewer's conclusion that there was excellent discharge planning when he returned to prison following his two inpatient admissions in 2012.

**The man's pain relief and medication**

41. Before he was diagnosed with cancer, the man took various medications for conditions such as high blood pressure and asthma. He had also been prescribed antibiotics for several chest infections over the course of the last year.

42. Following his diagnosis, the man took paracetamol to manage his pain. He also continued to take other medications, including a drug to prevent difficulty with breathing for people with COPD, which he took via a nebuliser (a machine that creates a mist of medicine that is breathed in through a mask). He was also given liquid nutritional supplements when he reported difficulty swallowing food.

43. Other than when he was admitted to hospital on 1 February 2012, the man did not complain of pain until the last few days of his life. On 6 and 7 April, he said that he felt sick and had vomited. He was prescribed cyclizine (medication to treat nausea and vomiting) and a fluid balance chart was started (to monitor his fluid intake and output).

44. The man continued to complain of nausea on 9 and 10 April. These symptoms were considered a side effect of his radiotherapy. He also began to complain of pain in his chest, for which he was prescribed prednisolone (a steroid medication used as pain relief) by a doctor. He was more unwell on the night of 11 April, and the night nurse was asked to monitor him every 30-45 minutes.

45. On the morning of 12 April, the man had deteriorated further. He was now experiencing dizzy spells, a cough, and increasing pain. The doctor examined him and diagnosed pneumonia. He prescribed morphine (used to treat severe pain) and amoxicillin (an antibiotic). The man continued to deteriorate and subsequently died.

46. The clinical reviewer concludes that the man was treated appropriately when he complained of nausea in April. Pain control was not an issue for him for much of his illness, and he only complained of increased pain in the last three days of his life. Changes to his medication were made promptly when he complained of increasing pain. The clinical reviewer concludes that his increased pain was treated appropriately. He also comments that the man received other comfort aids, such as oxygen therapy, in a timely manner.

**Palliative care plans**

47. During his hospital admission from 16 to 31 January 2012, the man signed a 'do not attempt to resuscitate' order (meaning that hospital or prison staff would not attempt to resuscitate him were his heart to stop beating). He confirmed to the modern matron that this was his wish. As we have noted previously, there was significant discharge planning ahead of the man's return to the prison following his two lengthy inpatient admissions in January and February 2012. This included a full assessment of his nursing needs. The man's mobility had

deteriorated by his return to Winchester on 22 February, and he now required a wheelchair.

48. A dedicated healthcare assistant was employed to help the man with his activities of daily living (meaning activities such as washing, dressing and cleaning), although he was encouraged to do as much as he could for himself in order to maintain his independence. We consider this to be a thoughtful and appropriate approach.

49. Before his discharge from hospital, the man was assessed by the hospital's palliative care team to ensure that he did not have any needs that could not be managed in the prison. A referral was also sent from the prison to the hospice to request an assessment from their specialists. The hospice's consultant in palliative medicine subsequently visited him in Winchester on 12 March.

50. During his visit, the consultant discussed radiotherapy with the man and confirmed his understanding of the aims of the treatment. The consultant also assessed his nursing needs. He concluded that the man did not currently have any specialist palliative care needs and did not therefore require ongoing input from the hospice. The consultant did not make arrangements to return for a second assessment, but advised the modern matron to contact the hospice should they require further input.

51. The man deteriorated very quickly in April and died unexpectedly the day after completing his course of radiotherapy. The clinical reviewer notes that his rapid deterioration meant that he died before an end of life pathway was required. However, we note that some of the principles of an end of life pathway, such as consideration of a 'do not attempt to resuscitate' order and the involvement of his family in care planning, had been implemented at an earlier stage.

52. The rapid deterioration in the man's health also meant that there was no further assessment from palliative care specialists at the hospice. Nevertheless, their advice, and that of the consultant oncologist, was sought by telephone on 12 April when the man became very unwell. We agree with the clinical reviewer's conclusion that his palliative care met expected levels and that he was "cared for very well" at Winchester following diagnosis.

**Liaison with the man's family**

53. The man's family visited him in hospital during his first inpatient admission, from 27 October to 17 November 2011. They later made a complaint to the Governor about the actions of one of the escorting officers. The complaint was investigated by the prison and is discussed further in the later section on restraints, security and bedwatch.

54. Following the man's admission to hospital on 16 January 2012, the modern matron and a Senior Officer (SO) went to the hospital to meet his family. The SO was appointed as the prison's family liaison officer and remained in contact with the man's daughters through the rest of their father's life. The prison paid for a hotel for the man's daughters during his first two nights in hospital, when he was very unwell and there were fears that he might not survive. We consider this a sensitive gesture. On 20 January, the SO spoke to the family about the various procedures that had to be followed were he to die in custody (such as the coroner's inquest and the Ombudsman's investigation). One of the man's

daughters later told our family liaison officer that this was handled sensitively and she was pleased to have prior warning of what to expect.

55. Ahead of the man's return to Winchester on 31 January, the modern matron telephoned the man's daughter to explain how he would be cared for on his return to the prison. The man moved into a cell on the healthcare centre, and his family were allowed to visit him on the unit rather than in the visits hall. His daughter was given contact numbers for healthcare and the SO.

56. The man's family visited him regularly during his hospital inpatient stay in February and following his return to prison later in the month. When he deteriorated, the SO telephoned his daughter to update her. The man's daughters were able to visit and spent the afternoon and evening with him in the healthcare centre. They were with him when he died at around 6.30pm. The funeral was held on 25 April and the prison contributed to the costs in line with national guidance.

57. The man's daughter told our family liaison officer that she received very good support from the SO and prison staff during her father's illness and after his death. We consider that the prison appointed a family liaison officer at the appropriate time and the support the family received from the SO, the modern matron and other staff reflects well on the prison.

**The man's location**

58. The man lived on C wing at Winchester before his diagnosis. Friends of his told the investigator that he got on well on the wing and his health was never so bad that he required assistance with daily activities (other than on one occasion when he had the flu for a few days).

59. Following his diagnosis, the man told the modern matron on 7 January 2012 that he wanted to stay on C wing where he could receive support from his friends. This wish was respected. However, following his hospital admission and surgery from 16 January to 31 January, the man's mobility was considerably reduced and he now required more significant nursing care. As such, he moved into a cell in the healthcare centre inpatients unit on his return and lived there for the remainder of his life (with the exception of the additional time he spent as a hospital inpatient). Various pieces of equipment were ordered in advance of his return, including a pressure relieving mattress. A full assessment of the man's nursing needs took place. A healthcare assistant was employed to assist him, and his friends from C wing were able to visit him in healthcare. Given the significant deterioration in the man's health, we consider this to be an appropriate move for him.

60. As discussed in the section regarding palliative care plans, the consultant in palliative care from the hospice visited the man in March 2012 and concluded that he did not have any specialist palliative care needs at the time. As previously noted, he deteriorated very quickly and his death came unexpectedly just a day after he completed radiotherapy. There was not therefore the opportunity to arrange a move to a hospice.

61. Consideration was given to admitting the man to hospital when he deteriorated on 12 April. However, it was considered by healthcare staff that he was too ill to move and the move might cause him undue distress. This was discussed with

his family, and telephone advice was taken from hospice staff and the consultant oncologist. We are satisfied that staff at Winchester took appropriate action at this time.

**Compassionate release**

62. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out as follows in Prison Service Order (PSO) 4700:

    - the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and

    - the risk of re-offending (particularly of a violent or sexual nature) is minimal; and

    - further imprisonment would reduce the prisoner's life expectancy; and

    - there are adequate arrangements for the prisoner's care and treatment outside prison; and

    - early release will bring some significant benefit to the prisoner or his/her family.

63. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS). Caseworkers in the unit consider the application and have a target of advising the prison of the outcome within two weeks of receipt (or sooner if the application is very urgent). Various reports are required to make up the application, including reports by the prison doctor (usually supported by further information from the hospital consultant or equivalent expert), the prison's probation officer and the Governor.

64. The man's application for early release was submitted in February 2012. The application included a report from respective specialists at the hospital and hospice. A probation officer at Winchester completed the offender supervisor's section. She did not support the man's immediate release, as he had not accepted the serious nature of his offence and had not, therefore, completed any offending behaviour work. The man's community probation officer completed the release plan. She explained that she would support his release once he reached the stage where he required palliative care and could move to a hospice.

65. The application was refused by PPCS on 1 March. There were three grounds for refusal. Firstly, that the medical reports submitted did not suggest that the man's death was imminent. Secondly, suitable release accommodation had not yet been identified. Thirdly, his offender supervisor did not support his release due to the risk he currently presented.

66. We consider it reasonable to refuse the application at this stage. The man was still to undergo radiotherapy and it would be right to see how he responded to this treatment and reassess his prognosis before determining whether the release criteria might be met. His death came quickly and unexpectedly, the day after he completed radiotherapy. As such, there was not time to consider and submit a further application.

**Restraints, security and bedwatch**

**Inpatient admission from 27 October 2011**

67. The Prison Service has a duty to protect the public and prison escort staff routinely use restraints when prisoners are taken out of the prison for any reason. However, there is also a responsibility to balance the need to hold prisoners securely with the duty to treat them with humanity and to maintain their dignity and privacy. Individual risk assessments should be completed on each occasion and regular management checks should be made to ensure the level of restraints used are necessary in all the circumstances. The risk assessment should consider the risk of escape and the risk to the public taking into account factors such as the prisoner's health and mobility.

68. When the man was admitted to hospital as an inpatient from 27 October to 17 November 2011, risk assessments were carried out before he left the prison and on his first full day in hospital (28 October). The assessors determined that he was a medium risk to the public on account of having recently committed a serious violent offence. They concluded that the man should be accompanied by two officers and restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to one of the escorting officers). This is a standard arrangement for category B prisoners who are hospital inpatients. Although the man had been admitted to hospital with increasing shortness of breath, he was still mobile at the time and had yet to be diagnosed with a life threatening illness. In the circumstances, we consider the decision to apply restraints to be appropriate at the time.

69. The Prison Service Security Manual instructs that the level of security must be kept under review to take into account factors such as the prisoner's developing medical condition. During his three weeks in hospital, the man's risk was reassessed on 9 November, when the duty governor wrote "current risk assessment is appropriate" on the back sheet of the risk assessment completed on 28 October. A full new risk assessment was not completed at any stage. He was diagnosed in hospital with an abdominal aortic aneurysm and probable lung cancer, both of which are life threatening conditions. We take the view that a full risk assessment ought to have taken place when he received news of these significant diagnoses.

**The Governor should ensure that a full risk assessment is completed when a prisoner in outside hospital is diagnosed with a potentially life threatening condition.**

70. The man's daughter wrote to the Governor to complain about the actions of a member of staff when she visited the hospital on 30 October. She said that the officer behaved in a rude and aggressive manner towards the family and would not allow them to give the man the confectionary they had brought for him. A local investigation was carried out by a manager at Winchester. She

recommended that the officer be given advice and guidance on interpersonal skills. She also recommended that the officer, who usually worked in the prison's healthcare centre, be assigned a role where he would not care for the man. The officer subsequently moved to a different role. In addition, the officer did not form part of the escort or bedwatch team during any of the man's future hospital visits. We are satisfied that the man's daughter's complaint was investigated appropriately and that suitable action was taken.

**Biopsy on 20 December 2011**

71. As we have noted earlier, the man had a biopsy at hospital on 20 December. The specific type of biopsy involves inserting a long, flexible tube (a bronchoscope) into the patient's mouth and threading it to the lungs. The bronchoscope is used to take images of the lungs and to remove cells for examination. It is usually done under a combination of sedation and local anaesthetic spray, or a general anaesthetic can be used if the patient is unduly distressed (there is no indication that this was the case for the man).

72. An escort risk assessment was completed ahead of the appointment, on 15 December, and highlighted that the man was a medium risk to the public and had medium potential to escape. The previous risk assessments, in October, had highlighted the man as low potential to escape. There is no recorded explanation for the increase in risk at this time, although we note that this was a planned rather than emergency admission. The medical section of the risk assessment was not completed. It was determined that he would be double cuffed for the escort (meaning that two pairs of handcuffs are used; one to cuff the man's wrists together and one to cuff one of his wrists to that of an officer). The cuffs were removed and an escort chain applied for the biopsy procedure itself.

73. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but we also take the view that security measures must be proportionate to a prisoner's individual circumstances. The man had not been assessed as a high risk of escape or to the public, and was an older prisoner who had been diagnosed with potentially life threatening illnesses. The clinical investigation that he underwent was particularly intrusive and we do not think the risk he presented warranted the use of an escort chain during the procedure.

**The Governor should ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including age and general health.**

**Inpatient admissions in January and February 2012**

74. No restraints were used when the man was admitted to hospital from 16 to 31 January with a ruptured aneurysm. He was very unwell during this admission and there were, at times, fears that he might not survive. We agree that it was appropriate not to use restraints at this time.

75. When he was readmitted to hospital on the night of 1 February, restraints were again not applied. The medical section of the risk assessment highlighted an objection to restraints being used and that he was so ill as to be incapable of escape. He was assessed as a low risk to the public and low potential to escape.

76. An escort chain was applied on the afternoon of 13 February. There was no indication in the bedwatch notes of the reason for the use of the escort chain (other than a note that it was done on the "duty governor's instruction") and no new risk assessment was completed. The duty governor on 13 February told the investigator that she made this decision because she was told that the man was now mobile and able to make his way to the bathroom on his ward. She went on to say:

> "If there is any doubt [about the prisoner's condition] you apply the [escort] chain because that prevents him from escaping, unless you get information from the hospital that his condition is so bad that it might impede medical treatment."

77. We note that he had been assessed as a low risk of escape in his most recent risk assessment. Although he might now have been able to walk to the bathroom, this does not mean he is physically capable of escaping from a two person escort. We also note that, two days after the escort chain was applied, the man collapsed after just two steps at a physiotherapy appointment. Indeed, by the time of his return to Winchester his mobility had deteriorated again and he now required a wheelchair. We take the view that his risk remained low and that a new risk assessment should have been completed before restraints were reapplied.

**The Governor should ensure that a new risk assessment is completed when a previously immobile prisoner in outside hospital regains some mobility. This should give thorough consideration to the prisoner's level of mobility at the time and ability to escape unaided. An escort chain should not automatically be used unless the risk assessment indicates otherwise.**

**Radiotherapy sessions**

78. The man required a wheelchair to mobilise by the time of his radiotherapy course in April 2012. He had five sessions in the first 11 days of the month, all at a local hospital. A separate risk assessment was produced ahead of each appointment. The assessments were inconsistent in their judgement of the man's risk. Although he was always assessed as a medium risk to the public, his risk of escape was sometimes marked as low and sometimes as medium. His wheelchair use was highlighted on each assessment, although the medical assessment sometimes recorded that he was too ill or incapacitated to be capable of escape and sometimes did not. Nevertheless, the same conclusion was reached each time: that an escort chain would be used during the escort, which would be removed during treatment.

79. The Prison Service Security Manual instructs that restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. This would apply in these circumstances. There is no evidence to suggest that the man presented a risk of escape or to the public that could not be managed by a

two officer escort.  Given the severity of his condition and lack of mobility, we do not think the use of an escort chain was necessary.

**The Governor should ensure that wheelchair users are not restrained on escort, unless the risk assessment indicates otherwise.**

## CONCLUSION

80. The man was unfortunate to have two life threatening illnesses diagnosed in the same hospital admission. Although we found that his cancer might have been diagnosed a few weeks earlier, its aggressive nature and the difficulty in identifying the specific type mean that the final outcome would not have been different. Nevertheless, there might be future occasions in which these few weeks might be key and we therefore recommend that NICE referral guidelines are followed when a prisoner presents with a persistent cough.

81. Although we found that the man could have been better supported in the weeks following his first hospital admission, he received very good support following the results of his biopsy. There was good communication between the hospital and prison healthcare staff to ensure that the right equipment and nursing care plans were in place before his return to Winchester following his lengthy admissions in early 2012. There are, however, learning points regarding the assessment of risk for terminally ill prisoners who are required to visit hospital.

82. The man's death came quickly and unexpectedly, the day after he finished a course of radiotherapy. This meant that he received limited input from local palliative care specialists. Nonetheless, we found that his palliative care was equivalent to that he might expect to receive in the community.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that medical staff follow NICE guidelines when treating patients who present with a persistent cough.

   *Accepted – All qualified nurses and GPs are aware of the British thoracic society guidelines for patients presenting with a persistent cough. A process links in well with the NICE guidelines for suspected cancer referrals. Several nursing staff are now trained in physical assessment and able to recognise red flag symptoms.*

2. The Head of Healthcare should ensure that prisoners diagnosed with a potentially terminal illness receive appropriate support from healthcare staff.

   *Accepted – Any prisoner diagnosed with a terminal illness would automatically receive a revised package of care. Arrangements are made to ensure continuous cover from healthcare support workers as well as qualified nurses to allow all patients to receive care in a private and dignified manner.*

3. The Governor should ensure that a full risk assessment is completed when a prisoner in outside hospital is diagnosed with a potentially life threatening condition.

   *Accepted – Risk assessment procedure has been reviewed and now compliant with this recommendation. The local security strategy has been amended to reflect this change in risk assessment.*

4. The Governor should ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including age and general health.

   *Accepted – Risk assessment procedure has been reviewed and now compliant with this recommendation. The establishment local security strategy has been amended to reflect this change of risk assessment process.*

5. The Governor should ensure that a new risk assessment is completed when a previously immobile prisoner in outside hospital regains some mobility. This should give thorough consideration to the prisoner's level of mobility at the time and ability to escape unaided. An escort chain should not automatically be used unless the risk assessment indicates otherwise.

   *Accepted – Risk assessment procedure has been reviewed and now compliant with this recommendation. The local security strategy has been amended to reflect this change in risk assessment.*

6. The Governor should ensure that wheelchair users are not restrained on escort, unless the risk assessment indicates otherwise.

   *Accepted – The local security strategy has been amended to reflect this requirement and all escorts now assessed prior to discharge.*