Investigation into the circumstances surrounding the death of a man at hospital, whilst in the custody of HMP Winchester, in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Winchester. He died in April 2010 at hospital. He was 49 years old. The cause of his death was established as bronchopneumonia and carcinoma (cancer) of the lung. I offer my sincere sympathy and condolences to his family, and all those affected by his loss. I also apologise for the delay in issuing this report and for any additional distress this may have caused.

The investigation was carried out by my colleague. An independent review of the man's medical care in custody was carried out by a clinical review team, including the clinical reviewer, on behalf of the local Primary Care Trust. I am most grateful to him and his colleagues for their contribution to the investigation.

I would like to thank the Governor and staff at Winchester for their full and ready co-operation during the course of the investigation.

The man was a Spanish national who spoke very limited English. The clinical review concluded that he received appropriate medical care whilst he was in prison. I make two recommendations, one to improve the timeliness of cardiology referrals and the other to review the arrangements for completing security risk assessments for the transfer of prisoners between hospitals. I also highlight as good practice the efforts made by Spanish speaking healthcare staff to translate the information about his diagnosis for him whilst he was in hospital.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

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SUMMARY

The man was a Spanish national whose English was very limited. He had a heart attack in 2007 and underwent a coronary artery bypass graft (surgery to treat coronary heart disease) in Spain. He was taking medication and was under the care of a cardiologist. He lived in Spain and was arrested at a port whilst entering the United Kingdom.

On 30 May 2009, he was remanded into custody at HMP Winchester. During the first two weeks of October, he twice complained of chest pains and was referred to a hospital cardiologist. The hospital concluded that the pains were not cardiac in nature but suggested a change to his medication for his heart condition.

In December 2009, he was sentenced to 15 years imprisonment. During January 2010, he saw prison doctors on a number of occasions about an ongoing cough. This was attributed to medication for his heart condition and he was told to stop using it. He was prescribed new tablets and referred to hospital for a chest x-ray, but this found nothing unusual.

At the end of January and throughout February, he complained of a swollen neck. Prison doctors concluded that this was an allergic reaction to the new medication and it was changed on several occasions, but the swelling continued. Consequently, he was admitted into hospital on 16 February. He was diagnosed with angioneurotic oedema (rapid swelling due to an allergic reaction) caused by the medication for his heart condition. He had a further two hospital admissions on 23 and 25 February, because of the swelling. On each occasion the hospital confirmed their initial diagnosis.

He continued to experience a number of symptoms and he was again admitted into hospital on 1 March. Following various tests, he was diagnosed with an aggressive cancer of the lung which had spread to his lymph nodes and was causing the swelling in his neck. Although the disease was incurable, the hospital planned to treat it once they identified his specific type of cancer. On 24 March, he was discharged from hospital and returned to Winchester.

The following day, he submitted an application to be repatriated to Spain. It was fast tracked because of his medical condition. On 9 April, Winchester was notified that the Spanish authorities had agreed to accept him. However, the following day, his condition worsened and he was transferred to hospital. He then suffered renal failure and was too unwell to have treatment for his cancer or to travel. There was a further deterioration and he was pronounced dead at 4.55pm.

A review of his clinical care found that he received a level of care that is equal to what would be expected in the community. I make two recommendations, one relating to referrals to specialists and another regarding the use of escort chains. I also highlight an example of good practice in relation to the efforts of medical staff to assist him understand his diagnosis.

THE INVESTIGATION PROCESS

1. The investigation was opened on 19 April 2010, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No prisoners or staff came forward as a result.

2. The investigator was given access to the man's prison file, including the medical record. He visited HMP Winchester on 9 June and 12 July and interviewed three members of staff. He also spoke on the telephone to an officer at HMYOI Portland who was the bedwatch officer when the man was in hospital.

3. An independent clinical review of his health needs whilst he was in custody was carried out by a clinical review team, led by the clinical reviewer, on behalf of the local Primary Care Trust. He joined the investigator at Winchester on 12 July.

4. One of the Ombudsman's family liaison officers wrote to the man's wife on 13 May, to inform her of the investigation and invite his family to raise any issues they wished the investigation to address. The letter was translated into Spanish. At the time of writing this report, his family have not raised any issues about his death. I hope that my report helps to clarify any issues that might remain unclear and helps them to understand what happened in the time leading to his death.

HMP WINCHESTER

5. HMP Winchester is a category B prison (category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult) built in 1846, for a maximum population of 554 male prisoners. 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. Prisoners who are serving longer sentences are often transferred to a different prison, but part of Winchester consists of a small category C training wing. (Category C prisoners are those who cannot be trusted in open conditions but who would not have the ability or resources to make a determined escape.)

6. From October 2008, primary healthcare services at Winchester were commissioned by the NHS and provided by the Community and Mental Health Services. In April 2010, provision transferred to Solent Healthcare. The healthcare department is located separately from the main prison building. It has a 22 bed inpatient facility (mostly for patients with mental health needs plus a few with primary care needs) and provides 24 hour cover. The majority of nurses work between 7.30am and 5.30pm. Three nurses work between 5.30pm and 8.30pm, and two work overnight. Doctors attend the prison from a local practice to hold surgeries in the mornings from Monday to Saturday, as well as offering an all day surgery on Tuesdays.

7. Winchester was last inspected by the then HM Chief Inspector of Prisons in April 2007. She found that there had been some improvements in the provision of healthcare, but some aspects of care were considered to be inadequate. In summary, Winchester was described as a “reasonably well-performing local prison”.

8. The Independent Monitoring Board (IMB) report for 2009-2010 found that there had been some improvements in healthcare. There were still some ongoing problems including a severe shortage of nursing staff and irregular association for prisoners in healthcare. (Association is the period of time when prisoners are unlocked from their cells and are able to mix with their fellow prisoners.)

9. The man’s death is the seventh to occur at Winchester since January 2008 and the third which was due to natural causes. The Ombudsman’s report into these previous two deaths due to natural causes, which occurred in 2009 and earlier this year, made recommendations which are unrelated to this case.

KEY EVENTS

10. The man was born in Spain in October 1960. He had been married twice and he had four children from his first marriage. He lived in Spain with his wife. He had worked as a lorry driver for 20 years until he had a heart attack in 2007. He then worked as a security guard. In 2009, he travelled from Spain to England in a lorry that was driven by someone else. On arrival in England, the vehicle was inspected and found to contain illegal drugs. He was arrested and charged with an offence related to the importation of drugs.

11. There is no information to suggest that he had previously visited the United Kingdom. He had one previous conviction in Spain for which he received a sentence of six months imprisonment in 2006. He spoke very little English. An interpreter was used when he was interviewed for his pre-sentence report. In addition, Spanish speaking prison staff and prisoners were also used to communicate with him.

12. He was remanded into custody at Winchester on 30 May 2009. He saw Nurse A, who spoke Spanish, for a reception health screen (a routine health screen for all new arrivals into prison). He said that he had been prescribed antidepressants the previous month which he found beneficial. He also told the nurse that he had a heart attack in 2007. He explained that he had a coronary artery bypass graft (surgery to treat coronary heart disease) and three stents (a tube that is placed in the arteries to keep them open). He said that he had ongoing annual reviews with a cardiologist (heart specialist). He said that he carried a glyceryl trinitrate (GTN) spray all the time, although he said that he never used it. (GTN medication is used to widen the arteries to increase the blood and oxygen supply to the heart.) He also told the nurse that he was taking other regular medication for his heart condition, but he had not had any for 24 hours. Consequently, he was admitted to the healthcare centre for 48 hours.

13. During his admission he was described as cooperating with taking his medication and no issues were noted. He was subsequently discharged from healthcare on 2 June.

14. On 6 June, his prescribed medication was reviewed by a prison doctor. Both he and Nurse A were present and the nurse translated the conversation into Spanish. Following a risk assessment, he was allowed to have his medication in his own possession. ('In possession' is when a prisoner collects one week or several weeks supply of medication at a time and keeps it in their cell to take as prescribed.) He was described as "fully alert" and it was noted that he understood what he should be taking.

15. Around a month later, in early July, Nurse A was asked by a senior nurse to translate his Spanish medical history which had been obtained from his community doctor in Spain. His high blood pressure, previous heart attack, depression and regular cardiologist check ups were noted. It was

agreed that healthcare staff would organise a follow up appointment with a cardiologist or make an alternative arrangement. It does not appear that this referral was made for some time. On 14 July, he saw a prison doctor who noted that he should continue with his medication and be referred to the smoking cessation unit. Again the referral was not progressed for a number of months.

16. He saw a nurse on 5 October, when he complained of pain in his chest. His GTN spray was empty and he was given a new one. He was comfortable and did not complain of any other symptoms, but the nurse noted that he was waiting for a cardiologist appointment. On the same day Prison Doctor A wrote to the cardiology department at the hospital. (This hospital is directly across the road from the prison.) Reference was made to his previous heart attack, his medication and his chest pain. The doctor said that he had examined him that day and an ECG (electrocardiogram is a test that records the rhythm and electrical activity of the heart) had shown no changes. However, the doctor's assessment was not reflected in the print out of the medical record. Nevertheless, he asked the hospital to consider doing another ECG whilst the man exercised.

17. On 13 October, the man saw Nurse B. He again complained of pain in his chest as well as tightness. He had used his GTN spray and expressed concern that the pain was similar to his previous heart attack. His blood pressure and pulse were taken and he was asked to reuse his GTN spray. The nurse concluded that he appeared to have had angina (pain or discomfort in the chest usually caused by heart disease) but, following the use of the spray, his condition had improved. The nurse assured him that he had been referred to the cardiology department at the hospital. However, he would ask the healthcare team to request that a prison doctor review his case. He added that, if the pain returned, the prison would arrange for him to be transferred to hospital. He was described as being "happy" with the plan. Prison Doctor B, a Spanish speaking prison doctor, also assessed him later on the same day. She made a further referral to the hospital. This involved resending the letter written by Prison Doctor A. However, she added a hand written note to say "angina at rest getting worse" and requested that he should be seen as soon as possible.

18. A week later on 20 October, ACCT monitoring was put in place for him. (Assessment, Care in Custody and Teamwork (ACCT) is a process to identify and care for prisoners at risk of self-harm or suicide.) The ACCT form recorded that he had said that he would hang himself if he was sentenced. In addition, it said that he had become "very withdrawn" and depressed after losing his job on the wing's servery. The ACCT was closed the following day as he was adamant he was just "having a bad day" and he gave assurances that he had no intention of harming himself.

19. His cardiology appointment took place on 27 October, at the hospital's Rapid Chest Pain Clinic. A letter outlining the findings was sent to Prison Doctor A at Winchester. His command of English was described as poor.

It was noted that the exercise testing had unfortunately been unavailable, but that an outpatient exercise treadmill test (to test the heart's ability to respond to external stress) would be arranged. The hospital concluded that it was unlikely that the chest pains were cardiac in nature. In closing, it was noted that he was taking an ACE inhibitor called trandolapril (Angiotensin Converting Enzyme inhibitors are a group of drugs used to treat heart disease and raised blood pressure). However, the hospital said that studies had shown that it had no benefits in patients with coronary heart disease. They suggested that there may be some merit in using an alternative ACE inhibitor. Consequently on 4 November, his prescription was changed to enalapril (ACE inhibitor).

20. A week later, he received an influenza vaccination at Winchester. He was not given the pandemic flu vaccination (an infection that affects the nose, throat and lungs and spreads on a worldwide scale).

21. On 19 November, he attended an appointment at the hospital's Cardiac Measurement Department for the treadmill stress test. A letter detailing the outcome was again sent to Prison Doctor A. The hospital confirmed that the test had taken place and that he had experienced no chest pain during the procedure. The hospital doctor said that it was reasonable to conclude that there was a "non-cardiac cause" for his symptoms.

22. Ten days later, Prison Doctor A examined him after he first complained about a cough that he had for a week. No abnormality was detected and he was prescribed amoxicillin (an antibiotic used to treat infections). He then made a written request for some cough medicine on 13 December, and he was prescribed simple linctus (medication to soothe coughs).

23. He went to court on 17 December, and he was sentenced to 15 years imprisonment. He saw Nurse A the same day. He said that he hoped to be transferred to a Spanish prison. He reported that he was in good health, but he had a "bad cold" for four weeks and a dry cough. The nurse said that there was no sputum (matter that is expelled through the mouth from the throat or lungs such as mucus or phlegm). She recorded that his mood appeared to be stable and he denied having any thoughts of suicide or self-harm.

24. Prison Doctor C, diagnosed him with acute tonsillitis (inflammation of the tissue on either side of the throat) two days later. He was given penicillin (antibiotic medication) for a week. Nurse A also reviewed him on the same day. He said that he was feeling well, but "upset" as he was "wrongly convicted". However, he felt "well supported" by staff and other prisoners. He added that he was hoping to be sent to Spain to serve his sentence. She offered to translate for him if required.

25. On 23 December, he again saw Nurse A. He said that he was feeling better since he started taking the antibiotics. His smoking was discussed. He said that he did not know about the smoking cessation clinics and would like to stop smoking. A referral was made and he was seen by the

stop smoking nurse on a number of occasions. In addition, a treatment plan was agreed and followed up.

26. The head of Winchester's performance unit wrote to the Seconded Senior Probation Officer on 24 December. He advised that the man had made an application for repatriation to Spain and asked him to prepare the necessary reports. The officer was unable to action the request immediately as he was on annual leave at the time. However, following his return to work on 5 January 2010, he started making the necessary enquiries. It was then discovered that he was appealing against his conviction and therefore the process was stopped. (This is in line with Prison Service policy which is set out in Prison Service Order (PSO) 4630 Immigration and Foreign Nationals.)

27. Prison Doctor D assessed him on 11 January, due to his ongoing cough. This had not got better despite taking antibiotics. He was examined and no abnormalities were detected. In addition, he had not experienced any weight loss or night sweats. (These symptoms are among those known as 'red flags' and are potential warning signs of a more serious underlying illness.) He was given a ventolin inhaler (medication to help breathing). The doctor also wrote to the hospital to request a chest x-ray to rule out any abnormalities.

28. He was assessed by a nurse on 17 January, when he continued to complain about a dry cough. The nurse noted that his English was limited. However, through "finger points", he communicated that he had generalised chest pain which was aggravated by the cough. He was examined and it was noted that his skin looked "flush" and he was "clammy to touch". He was given paracetamol and Gaviscon (treatment for heartburn and indigestion). He was reviewed in the afternoon by the same nurse. He looked much better and confirmed that this was the case. An appointment was booked with a prison doctor the following day, but this did not take place. It is not clear why this appointment did not go ahead.

29. The man attended an appointment two days later on 19 January, with Prison Doctor B. She concluded that the ACE inhibitor was causing his cough and advised him to stop taking the medication. The doctor asked for his blood pressure to be monitored by the nurse. He was also told that different medication would be prescribed. On the same day he was prescribed candesartan (to treat high blood pressure).

30. Towards the end of January, he complained about chest pains. He was assessed by a nurse who noted the absence of flushing and clamminess and prescribed paracetamol. The nurse concluded that the chest pains appeared to be due to "incessant coughing". A further appointment was booked with a doctor.

31. He was examined by a doctor two days later. He refused to take candesartan as he felt that it was causing swelling in his neck. He also

said that he wanted to go back on enalapril. It was agreed that he would stop taking his current medication and revert back to enalapril. On 31 January, he saw a nurse and returned the candesartan as well as another ACE inhibitor and was prescribed enalapril.

32. On 2 February, he attended his scheduled appointment for a chest x-ray at the hospital. The hospital's clinical report noted the transverse diameter (a type of measurement) of the heart was not enlarged. In addition, the lungs, mediastinum (middle section of the chest) and pleura (the thin covering that protects and cushions the lungs) appeared normal. There was also no focal lesion (injury, infection or growth) or evidence of tuberculosis (an infectious disease that affects the lungs). Therefore nothing unusual was detected. The following day, Prison Doctor D also ordered other tests to be completed.

33. Nurse A was asked by a landing officer to assess the man on 5 February, because he was very distressed. On arrival, the nurse said that he was shouting and agitated. He complained that no one was listening to him and said he had seen the doctor several times, but nothing had been done. He asked to see the doctor again due to his ongoing dry cough. He explained that he felt unwell and had not received his medication. She discussed his concerns, offered to translate for him and agreed to make an urgent doctor's appointment. She also suggested that he took his Spanish medical records and his medication to his appointment. She recorded that his neck still appeared to be swollen.

34. His appointment with Prison Doctor E took place on the same day. On examination no swelling was found, but he still had a cough. His medication was reviewed; the use of the ACE inhibitor was stopped and changed to valsartan (to treat high blood pressure). He had a further appointment with the same doctor two days later when a translator was present. No swelling was seen and it was agreed to wait and see his response to the new medication.

35. Three days later he had an appointment with a nurse who recorded that he had a swollen face and neck. She concluded that this might be an allergic reaction to valsartan and prescribed him tablets to treat the swelling until he could be reviewed by a doctor. He was again reviewed by a nurse on 13 February, and it was noted that his eyes were now also swollen. Consequently, the nurse took the valsartan medication away from him. She assessed him again two days later. He reported dizziness, tenderness to the neck and some vomiting. Whilst the allergy tablets had provided some relief, the swelling had not completely gone.

36. Prison Doctor D reviewed his case on 16 February in his absence. The doctor had asked a nurse to bring him to the healthcare department. However, due to "logistical issues" this was not possible. He requested that nursing staff "keep an eye" on him to identify symptoms that were of particular concern. In addition, nursing staff were told to consider a number of responses in the event that his condition deteriorated.

37. During the afternoon, the swelling in his neck got worse and a nurse referred him to the hospital's Accident and Emergency Department. He attended hospital and was diagnosed with angioneurotic oedema (rapid swelling due to an allergic reaction) due to the ACE inhibitors. He was given prednisolone (steroid medication to treat an allergic reaction) and discharged from hospital later the same day. Prison Doctor D reviewed his medication the next day and noted that ACE inhibitors were no longer to be issued.

38. On 20 February, a nurse made an emergency doctor's appointment for him. She examined him after prison staff had expressed concerns about the continued swelling in his neck. Another prisoner translated for him and explained that he felt worse and was also having problems swallowing. Prison Doctor C assessed him later in the day and concluded that there was "no indication for acute intervention [hospital assessment]", but that he might need to be reviewed by the hospital if his condition deteriorated. The doctor reviewed his hospital chest x-ray which had been taken on 2 February, and noted the results from the hospital.

39. A landing officer asked for a nurse see him on 22 February, after he had more difficulty swallowing. Nurse A noticed that he had not been taking the correct dosage of the prednisolone prescribed by the hospital. She documented that new tablets would be issued by healthcare and the matter would be discussed with the prison doctor.

40. The following day, he was examined by another nurse. He was described as experiencing a number of symptoms, including shortness of breath. An ambulance was called. Whilst paramedics were present, he lost consciousness for approximately two seconds. He was taken to the hospital and discharged on 24 February, again with steroid tablets and an antihistamine to treat his allergy. The report from the hospital repeated that his condition was due to the use of ACE inhibitors and he should avoid any further use of this medication. In addition, the hospital made an appointment for him to have a neck ultrasound (a technique to produce internal images of the body) on 5 March. When he returned to Winchester, his medication was reviewed by a nurse who ensured that he understood how to take his new tablets. However, there is no indication how this was established.

41. He was assessed by two different nurses on three separate occasions during the course of 25 February. When he was first examined, it was noted that his face was still swollen. The nurse said that he misunderstood the dosage of his medication and this was explained with the assistance of prison officers. The language barrier remained an issue, but the nurse added that the use of an interpreter on the wing was helpful. On the second occasion, wing staff called the same nurse as he had woken up from sleep and was considered to be anxious. He was again examined, but no changes were noted. The nurse advised him to take his medication as prescribed.

42. A different nurse later checked him. Through the use of an interpreter, he said that he was finding it difficult to breathe and his neck had swollen up again. Due to the deterioration in his condition, he was sent to hospital. He was discharged the same day and prescribed a different type of antihistamine. He was reviewed by a nurse on his return to Winchester. He was anxious and tearful, but reassured by the nurse through a Spanish speaking prisoner. Arrangements were made for him to share a cell with this prisoner, partly to facilitate communication if his condition got worse.

43. The following day, he saw a prison nurse. She was concerned that he was not taking his medication correctly and made several attempts to take it off him. However, he refused to give it to the nurse. Through the use of an interpreter, the nurse tried to explain the reason for her concern, but he became agitated and upset. The nurse noted that she did observe him taking his medication.

44. On 27 February, a nurse reviewed him as he had become dizzy and fallen over. He remained agitated about his swollen neck and said that no one was doing anything about it. The hospital was contacted for advice. They said that, if there was any deterioration in his condition, he should be referred back to them. He reluctantly agreed to go to healthcare so that his condition could be monitored. Arrangements were made for his previous cell mate to act as a Listener. (A Listener is a prisoner trained by the Samaritans to listen and offer support to their peers.) He was described as being tearful. He continued to experience dizziness and remained anxious. A measurement was taken of the base of his neck. His vital signs (measures including blood pressure, pulse and body temperature) were noted as stable and efforts were made to reassure him and make him comfortable.

45. The following day, he was examined by Nurse A. He said that he had been unable to breathe following a shower, he had also experienced shortness of breath and he had lost consciousness the previous day. All his vital signs were normal. In addition a further measurement of the base of his neck was taken, which was one centimetre less than that of the previous day (indicating that the swelling had reduced slightly). The nurse recorded that she had spoken to his cell mate. He said that the man did seem to lose his balance and he had ended up on the floor. However, he had not lost consciousness.

46. Prison Doctor F reviewed him on 1 March. The doctor admitted him into the hospital on the same day, on account of his recent dizziness. Each time that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (either single or double handcuffs or two metre long escort chain with a handcuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. In his case, the risk

assessment determined that two officers should be deployed and he should be cuffed to one of them using an escort chain.

47. Following various tests over a three week period, he was diagnosed with cancer of the right lung involving the lymph nodes (an organ of the immune system). Hospital doctors confirmed that his lymph glands were enlarged which was preventing blood flow and causing the swelling in his neck. An initial biopsy (a medical test involving the removal of cells or tissues for examination) had been attempted to confirm the specific type of cancer (and therefore ensure that the most effective treatment could be provided). The procedure could not be carried out as he had a nose bleed. A further biopsy was done, but the result was inconclusive as there were insufficient cells. His prognosis was difficult to determine until his response to chemotherapy (treatments using drugs to kill cancer cells) and radiotherapy (treatment using high energy radiation) could be assessed. However, Prison Doctor B was subsequently told that the cancer was incurable, although the plan to treat him would continue. During his admission, prison healthcare staff kept in regular contact with the hospital. In addition, he was visited on numerous occasions by Nurse A, who interpreted for the hospital. The same doctor also translated the diagnosis to him on 24 March, when this was explained by the hospital. During his hospital admission, he kept in regular contact with his family in Spain.

48. During his time in hospital, he occasionally became angry towards the escorting officers or hospital nurses. On 2 March, he was described as "upset and angry" because he could not smoke. (It is a hospital policy that smoking is not allowed anywhere on their premises.) Three days later, he was reportedly abusive to one of the escorting officers when told that the escort chain could not be removed for him to wash his face. On 8 March, he "demanded" to go outside to smoke. He was reportedly aggressive when told that he could not do so and then went to the toilet and started to smoke there instead. During her visit later that day, Nurse A reiterated to him, in Spanish, that he was not allowed to smoke in the hospital.

49. The following day, he tried to "push past" the escorting officers to go outside for a cigarette. The officers reported that they "assertively" told him he was not allowed to leave the ward, but did not use 'control and restraint' techniques (the method approved by the National Offender Management Service to restrain violent prisoners by using force). Later that day, he reportedly "swore" at hospital nurses as he was not allowed to smoke. Nurse A returned to the hospital later that day to try again to explain that he could not smoke.

50. He was discharged back to Winchester on 24 March and Nurse A assessed him the next day. Overall, his mood was described as stable and he said he was not afraid of dying, but wanted to see his family before he passed away. He wanted to reapply for repatriation to Spain and was helped to complete the relevant paperwork. He was assured that the offender management unit were dealing with the matter. The following

day, he complained of bruising at the sites where he had enoxaparin injections (medication to prevent blood clots in patients who are confined to bed).

51. On 26 March, he was admitted into another hospital to insert a stent for a blockage to one of the veins leading to his heart. He was again escorted by two officers and cuffed to one by means of an escort chain. On the same day, the Spanish Consulate contacted healthcare for information and they were redirected to the Probation Officer. It was also noted on the medical record that Prison Doctor B would complete a medical report for the Home Office in relation to his repatriation.

52. The following day, he was discharged from hospital. The stent could not be inserted as his vein was clotted with blood. Later that day, he complained of chest and stomach pains and was taken back to the first hospital. The same escort arrangements applied as previously. A few days later on 29 March, the second hospital told Prison Doctor B that another lung biopsy would be done so that the hospital could determine the type of treatment that the man should receive.

53. The medical report was completed by Prison Doctor B for the man's repatriation on 30 March. She said that his condition was serious and there was no guarantee that it would "not turn grave at any moment". She added that he was fit to return to Spain. The application was sent to the Cross Border Transfer Section of the United Kingdom Border Agency (UKBA) on the same day. The Probation Officer asked that the application be fast tracked on account of the man's medical condition. The application was forwarded to the Spanish authorities the following day.

54. On 30 March, he was re-admitted to the second hospital. He had keyhole surgery (a procedure using cameras and special instruments through small incisions in the body) the following day, in order to take a biopsy of the lymph nodes in his chest. He was discharged on 3 April, to the prison's healthcare department. Later that night, he was examined by a nurse and found to be very pale, clammy and short of breath. Following consultation with the hospital, an ambulance was called and he was taken back to the hospital.

55. He was discharged from hospital in the early hours of 4 April, with the understanding that he could return if there was any deterioration in his condition. Nurse A and another nurse reviewed him on a number of occasions that day. He complained of lower back pain and his breathing was shallow and wheezy. His mood was also described as low. Consequently, he was moved to a single cell near to the nurses' station and visits from Spanish speaking prisoners were arranged. In addition, Nurse A made arrangements for him to make a telephone call to his family.

56. On 6 April, it was noted that the Probation Officer had processed his repatriation application to Spain. On the same day, he was assessed by Prison Doctor B and prison nursing staff. The doctor noted several bruises over his chest and abdomen, but gave no indication as to the cause. On one occasion a Spanish speaking prison visitor was used to translate for a nurse. During the day, he reported pain, vomiting, nausea and feeling weak. He was prescribed medication to ease his pain. Later, due to ongoing concerns about his chest pain, he was re-assessed by an out of hours doctor using a telephone interpreter. He declined to go to hospital, but this option remained open to him the following day. Nursing staff also requested advice about palliative care (treatment to reduce the severity of symptoms rather than seeking to provide a cure) and input from Macmillan (registered charity that provides support to those affected by cancer).

57. The next day he was assessed by a nurse. He appeared to have had a more settled night. The hospital declined to admit him unless his condition deteriorated. His pain control medication was reviewed. There was contact between nursing staff and the hospice (specialist palliative care service). They confirmed that they had a referral for him and anticipated assessing him within a week. In addition, he was also referred to the Macmillan nurse.

58. On 9 April, Winchester received a fax from a staff member of the Prison Service Cross Border Transfer Section. She said that the Spanish authorities had given their approval for his repatriation, but his signature was required on the consent forms. She added that, once this had been done and the forms returned, they would be sent to Spain and a date for repatriation would be arranged.

59. His condition deteriorated on 10 April. He was assessed by a nurse and described as weak, disorientated and confused. In addition, he also experienced shortness of breath, abdominal pain and he had been unable to sleep. A nurse contacted the hospital and it was agreed that he should be taken to the accident and emergency department. Arrangements were made beforehand for him to telephone his family. An ambulance was subsequently called and he was admitted to hospital. A governor decided that no cuffs were required on this occasion.

60. The prison bedwatch officers were later told by a hospital doctor that he did not have long to live (although no specific timeframe was mentioned). The following day, the officers noted that he remained confused, restless and he did not eat any food.

61. On 12 April, a risk assessment was completed to determine the security arrangements that should be in place during his stay in hospital. It concluded that he was a medium risk to the public and there was a medium risk of him trying to escape. A governor confirmed that two officers would accompany him in hospital and no restraints were to be used.

62. Prison Doctor B visited him on 13 April. He had renal (kidney) failure and he gave his consent for prison staff to speak to his wife. The doctor told him that his wife was trying to travel from Spain to see him. The hospital agreed to provide further medical reports to help his wife obtain a visa. He was now too unwell to have chemotherapy or radiotherapy. Later that day, a prison nurse spoke to staff at the hospital. They said that his prognosis was poor and he was too ill to travel.

63. The following day, his condition did not improve. He was very confused, his appetite was poor and he had not slept. Prison nursing staff communicated with the Spanish Embassy and established that his wife was travelling to England to see him. This had taken a while to organise as his wife is a Colombian national and she needed to obtain a visitors visa. Arrangements were made for her and a social worker to visit him the next day. His daughter was also told about the gravity of his condition.

64. His family visited him on 15 April. A representative from the Spanish Embassy was also present. He told his wife that staff had assaulted him which resulted in bruising on his arms. Through the Embassy representative, an officer, who was on bedwatch duties, assured the man's wife that this was not the case. She was told that he had not been restrained and neither had he been hand cuffed. The officer later told the investigator that, after this allegation was made, he telephoned Winchester and asked the duty governor to visit. The duty governor subsequently visited the hospital and spoke to the wife through the Embassy representative. The officer told the investigator that this appeared to resolve the situation. He said that at no time did he or his colleague "lay hands" on the man.

65. Later that day, hospital staff decided to move him to another hospital to continue his treatment. An escort chain was used during his move. This instruction was given by the duty governor, but a note was made by the officer that the use of restraints would be clarified nearer to the time of transfer. There was no indication that this occurred. The escort chain was used and removed and he arrived at the other hospital.

66. His condition deteriorated and his family were contacted. They were at his bedside when he passed away. He was pronounced dead at 4.55pm. The cause of death was cancer of the right lung and bronchial pneumonia. His body was repatriated to Spain where his funeral was held. The prison contributed towards the cost of the funeral. In addition, Winchester also met the costs of accommodation for his wife during her visit.

67. Following his death, the investigator spoke to a Detective Inspector (DI) of Hampshire Constabulary. He said that the man's son reported that his father told him, on 14 April, that he had been assaulted in prison on either 8 or 9 April. His son said that his father told him that two prisoners had approached and threatened him, wanting him to join their gang. When he refused, he told his son that he was assaulted by the two prisoners.

68. The application for repatriation was approved by the Spanish authorities following the receipt of the signed documentation. They contacted UKBA on 22 April with a view to arranging a transfer to Spanish custody. They were told that he had sadly died five days earlier.

ISSUES

Delay referring the man to the cardiologist

69. The health screen assessment on 30 May 2009 identified that the man previously had a heart attack and that he had regular check ups with a cardiologist. Around six weeks later, his Spanish medical records confirmed this information. Healthcare staff then planned to make a cardiologist appointment. After he complained of chest pains, a referral was sent to the hospital's Cardiology Department on 5 October. This was followed up a week later when he experienced similar pain and also tightness in his chest.

70. The clinical reviewer notes that it appeared that the hospital did not receive the referral on 5 October. Notwithstanding this issue, he considered that the man's symptoms between 12 and 13 October suggested a cardiac episode. Therefore, a hospital admission would have been appropriate rather than re-sending the referral letter with an explanatory note. However, the clinical reviewer notes that despite the "suggestive history subsequent investigations were normal".

71. I believe that his disclosure that he was under the care of a cardiologist should have prompted a much earlier referral. The Head of Healthcare acknowledged this in a report completed shortly after his death. She concluded that "referrals should be carried out in a more timely fashion".

72. I am particularly concerned that the referral was only triggered because he complained of chest pains. This was two months after a referral was requested following receipt of his Spanish medical records and over four months after his initial health screen assessment. Given his recent significant cardiac history, an early referral should have been made.

    The head of healthcare should ensure that arrangements are in place to make timely cardiology referrals where it has been identified that a prisoner is under the care of a cardiologist in the community.

Referral for smoking cessation treatment

73. On 14 July 2009, a prison doctor noted that the man should be referred to the smoking cessation unit. However, it was over five months before this was done. The referral was eventually triggered when he saw a nurse on 23 December and asked for more medication. It was during the course of this meeting that the issue of smoking was discussed. Whilst a treatment plan was established and subsequently followed up, a timely referral would have enabled earlier intervention.

74. The clinical reviewer notes that he was encouraged to stop smoking and he received smoking cessation treatment. He adds that he started to smoke again once he was diagnosed with cancer. This was his personal

choice. Nevertheless, the clinical reviewer concludes that the initial treatment was a "very worthwhile health intervention".

Timeliness of the man's diagnosis of cancer

75. The man reported experiencing a cough from the end of November 2009 to January 2010. Initially, no abnormalities were detected and he was prescribed antibiotics. Around the middle of January, Prison Doctor B attributed his cough to the ACE inhibitor. He was advised to stop using it and prescribed candesartan instead.

76. Towards the end of January and throughout February, he complained of a swollen neck. He saw a different prison doctor on 30 January, and he refused to take candesartan as he believed it was causing the swelling. Consequently, he was prescribed another ACE inhibitor.

77. A chest x-ray on 2 February detected nothing abnormal. Prison Doctor E saw him three days later and he was again told to stop using the ACE inhibitor. His blood pressure medication was changed to valsartan. Between 7 and 13 February, he experienced further swelling in his face. It was concluded that his condition was an allergic reaction to valsartan. However, the swelling continued and he was admitted into hospital on 16, 23 and 25 February. The hospital diagnosed angioneurotic oedema (rapid swelling due to an allergic reaction) caused by an allergic reaction to ACE inhibitors and instructed that he should stop using all such medication.

78. On 1 March, he was again admitted into hospital due to ongoing concerns about his condition. Following tests, he was diagnosed with cancer of the right lung which had spread to his lymph nodes (glands).

79. In the clinical review, the clinical reviewer explains that when he presented with his persistent cough on 11 January, he did not have "red flag" symptoms such as weight loss or night sweats. However, he notes that he was in any event referred for a chest x-ray and the results were considered to be normal. In addition, further investigations were also ordered and nothing unusual was identified.

80. The clinical reviewer notes that the chest x-ray has been reviewed by radiologists since the man's death. They "acknowledged, with hindsight" that the central part of his chest was "slightly wide on the x-ray". This could be an indication of a more significant problem. However, the clinical reviewer says that he did not have a "corresponding legion in his lungs to trigger more concern". Therefore, the radiologists confirmed that the x-ray results were "within normal limits". He adds that the initial assessment that the chest x-ray was normal did slightly delay the diagnosis of cancer. However, he explains that due to the aggressive nature of the tumour and the manner in which it had spread, the delay did not affect the outcome and his condition was already terminal.

81. The delay in the tissue diagnosis is also addressed by the clinical reviewer. The clinical reviewer notes that a number of attempts were made in hospital to obtain a tissue sample to establish the man's particular type of cancer. However, this was not possible due to his heavy nose bleed and an "inadequate sample". The clinical reviewer adds that this is not unusual. He concludes that the type of tumour had to be identified "to offer the most effective form of cancer treatment".

82. In summary, the clinical reviewer says that the initial symptoms were "very reasonably put down to adverse reactions to the medication he was receiving for his heart condition". He goes on to add that within three weeks he was reassessed and diagnosed. The clinical reviewer considers that such a delay would be similar in the community, due to the "unusual combination" of his "signs and symptoms". He concludes that this delay did not have an impact on the outcome for him because of the "extremely aggressive nature" of his disease.

Language barrier

83. The medical record documents a number of occasions when the man was unclear about his medication and the dosage. The investigator spoke to Nurse A, herself a Spanish speaker, about her observation documented in paragraph 36 that he misunderstood the dosage of prednisolone on 22 February. She explained that he thought that he had been prescribed too many tablets. There was another incident on 24 February, but it is unclear what method was used to confirm that he understood how to take his medication correctly. However, on 25 and 26 February, when he remained uncertain, Spanish interpreters were appropriately used to clarify the situation.

84. Between 19 January and 25 February, I am mindful that he experienced numerous changes to his medication for understandable medical reasons. This seems to coincide with his uncertainty and it is therefore reasonable to conclude that these alterations may have contributed to his confusion. However, overall I am content that reasonable steps were taken to ensure that he understood his medication regime when it was evident that he was unclear.

85. Throughout the medical record his understanding of English was described as poor. The investigator spoke to Nurse A regarding his comment on 5 February that "no one is listening to him". She explained that this was partly related to the language barrier, but also concerned the absence of information about his chest x-ray results. It is understandable that he felt anxious about his condition. Therefore, it would have been prudent for arrangements to have been made to let him know the outcome of his x-ray when it was received on 2 February.

86. On 5 February, he also expressed concern about not being understood. Nurse A appropriately offered to translate for him. In addition, she suggested that he took his Spanish medical records and medication to his

next doctor's appointment. There is no evidence that prison doctors or nurses misunderstood his concerns about his health.

87. The Head of Healthcare at Winchester said that she was confident that he understood his cancer diagnosis and treatment due to the contribution of Nurse A and Prison Doctor B. She added that the prison also used language line (telephone translating service), although Winchester tended to utilise Nurse A given her medical knowledge. I also note that the nurse and doctor both went to the hospital during the man's admission to assist with translating. I consider this to be particularly compassionate, as he knew them and they were involved in his ongoing care. This is an example of good practice.

88. I am satisfied that all reasonable steps were taken to explain to him in Spanish his medical conditions and treatments as events unfolded. Appropriate use was made of various methods of translation. Winchester is fortunate to have Nurse A and Prison Doctor B who both speak Spanish and had frequent contact with him. I have no doubt that this made a significant contribution to improving his understanding about his condition within the prison and during his hospital admissions.

Repatriation

89. He made an application for repatriation to Spain in December 2009. However, once it was discovered that he was appealing against his conviction, his application was not progressed. This was in line with Prison Service Order (PSO) 4630 which specifies that a number of criteria must be met before repatriation takes place. This includes the stipulation that prisoners must not have any outstanding appeals. (Prison Service Orders are national policies that apply throughout the Prison Service.)

90. The Probation Officer told the investigator that the man reapplied for repatriation on 25 March 2010, and said that he was no longer pursuing an appeal. This was a day after he was told that he had cancer. The Probation Officer then spoke to the member of staff in the Cross Border Transfer Section (which deals with repatriation applications) and asked for his application to be expedited due to the serious nature of his condition. He said that the repatriation application had been sent to the Cross Border Transfer Section on 30 March. The staff member confirmed that it was received on the same day and then sent to Spain on 1 April. She explained that the Spanish authorities approved his repatriation on 5 April. Four days later, the staff member wrote to Winchester about the decision and requested that the man signed the consent forms. However, his condition deteriorated on 10 April and the prison were told that he did not have long to live.

91. On 22 April, the Spanish authorities contacted the Cross Border Transfer Section to arrange a transfer date and to check on the man's condition. However, when they contacted the prison they were told that he had passed away on 17 April.

92. The man's repatriation application was processed quickly and a positive decision was received from Spain within 11 days. Unfortunately, he deteriorated rapidly and passed away before final arrangements could be made for him to be repatriated to Spain. Nevertheless, I will arrange for a copy of my report to be sent to the Cross Border Transfer Section in recognition of the importance of the timeliness of their work.

Flu vaccination and record keeping

93. The clinical reviewer notes that the man was identified as having coronary heart disease (CHD). He explains that, whilst he was given an influenza injection, he did not receive the pandemic flu vaccination (the infection affects the nose, throat and lungs and spreads on a worldwide scale), although this is indicated for patients with CHD.

94. He finds that the man's records were more comprehensive than others that had recently been reviewed. However, the use of "read codes" (medical codes) was "still inconsistent, and at times inaccurate and remained below the standard of most NHS general practice".

95. These two issues, he explains, will be addressed by the introduction of a new national computer system. He goes on to say that this will ensure better and more consistent coding as well as closer monitoring. He concludes that this should "improve the health outcomes for patients by ensuring that they are offered preventative measures such as pandemic flu vaccinations".

Continuity of care

96. The man saw five different prison doctors during his time at Winchester. The clinical reviewer concludes that this led to a lack of continuity of care. Some of the changes were attributable to Prison Doctor B's absence due to maternity leave between the end of January and 22 March 2010. I am mindful that during this period he was restarted on an ACE inhibitor on 30 January, despite being advised some ten days previously to stop using the drug by the doctor. Nevertheless, the clinical reviewer notes that the rapid progression of his symptoms did result in appropriate referrals for a chest x-ray and to hospital for treatment. In addition, the record keeping also enabled a "clear thread to be followed through his [the man's] care". The clinical reviewer confirms that Winchester is taking steps to improve the continuity of care including encouraging prison doctors to follow up their "own" patients. He notes that the doctor's return should ensure that this will happen.

97. The Head of Healthcare repeated that Winchester is working towards better continuity of healthcare by ensuring that the same nurses consistently work on the same wing. She added that this would enable them to assess changes to patients rather than a different nurse seeing them each day.

Use of restraints in hospital from 1 March to 24 March 2010

98. The man was admitted to hospital on 1 March 2010 following a spell of dizziness. A standard inpatient escort of two officers, with an escort chain, was exercised. During his time in hospital, he underwent various tests. Shortly before his return to prison on 24 March, the diagnosis of cancer was confirmed.

99. He remained mobile during this period in hospital. Although he was often said to be pleasant and polite there were a number of occasions when he became aggressive towards escorting or hospital staff. This was usually related to him not being allowed to smoke in hospital. (Neither patients nor staff are allowed to smoke anywhere on the hospital premises or grounds. However, prisoners are allowed to smoke within their own prison cells.) It is not clear how or when he was originally told that smoking was not permitted in hospital, unlike in prison, and whether the language barrier was therefore an issue in his understanding. However his aggressive behaviour continued, albeit to a seemingly lesser extent, after Nurse A visited on 8 March and told him in Spanish about the ban.

100. I have some sympathy with his situation, given that he spent a lengthy period in hospital undergoing various tests that eventually led to a serious diagnosis. However, a significant role of the escort staff is the protection of the public, including hospital staff. Given his conduct and that he was still mobile, I consider the use of an escort chain to be appropriate during this period.

Use of restraints in hospital from 10 April 2010 onwards

101. Following his hospital admission on 10 April, a risk assessment advised that he should be accompanied by two prison officers and that restraints should not be used. The investigator discussed his mobility at the time of his April hospital admission with the Head of Healthcare. She described it as limited. She added that he was only able to walk a few yards with assistance. In view of his medical condition, she considered that his security risk was minimal. I consider this to be an appropriate and respectful decision given his health at the time.

102. However, a further risk assessment was not completed to determine his security risk before he was transferred between the two hospitals on 15 April. At the time of his transfer he was in a very fragile state. I am therefore surprised about the decision to use the escort chain, especially as no restraints were assessed as being necessary during his hospital admission. Whilst the record of events noted that clarification would be sought about the use of the escort chain, there was no evidence that this was done. Under the circumstances, a fresh risk assessment would have been appropriate, especially as there had been a significant decline in his condition.

The head of security should review the arrangements for completing escort risk assessments for prisoners being transferred between hospitals.

103. In the days prior to his death, his condition had deteriorated and he suffered renal failure. I believe that it was right to remove the restraints once he arrived at the second hospital.

Allegation of assault

104. On 15 April, he told his wife that he had been assaulted earlier that day. His son also later reported to the police that his father had said he had been beaten up in prison on either 8 or 9 April. The investigator discussed these allegations with a number of staff and also with the police investigating officer. The allegations were reported to the duty governor who spoke to the family and the officers on duty. No formal investigation took place.

105. Nurse A said that she was unaware of any such incident within the prison. She went on to say that she handed over his property to his family following his death on 17 April. She described them as being "concerned and angry" about the bruising on his body. In addition, they repeated his allegation that he had been beaten up whilst he was in hospital. The nurse added that restraints had been used during a previous period in hospital and he had tried to smoke without permission during this time. Given that he was reported to be "incoherent" around the time he made the allegation of assault, it is possible that he was referring to this period.

106. The bedwatch officer told the investigator that the social worker from the Spanish Embassy had approached him on 15 April. She too said that the man reported that he had been "beaten up or restrained" that morning. The officer explained to the investigator that he told her that he had not been wearing cuffs or a chain. He added that the bruising on his arm was due to nursing staff taking blood. The officer recalled that the man was not very coherent that morning and he was too weak to have a conversation.

107. The Head of Healthcare was unaware of an assault taking place or it being mentioned by any prisoner or member of staff. Similarly, another nurse said she had no knowledge of such an incident. However, the family told the police that the assault in the prison took place in the kitchen. The Head of Healthcare pointed out to my investigator that the kitchen is opposite a gated cell (a cell with a barred gate rather than a door, to allow closer observation of a prisoner deemed to be at risk of suicide or self-harm) that accommodates patients on constant supervision. She believed that a prisoner was in this cell when the alleged assault took place. Therefore, an officer would have been required to be constantly present within a few yards of the kitchen. No incidents of this nature were reported by any officer including those carrying out the constant supervision.

108. The post mortem report considers the marks on the man's body when he died and concludes as follows:

> "[The man] had no evidence of any significant injury and there was nothing to indicate that he had been forcibly restrained or involved in a struggle."

The police investigating officer told the investigator that he had discussed the bruising with a dermatologist at the hospital. The dermatologist told him that all of the bruising was caused by medical care, with the exception of a small area on the man's foot. The police officer told the investigator they were satisfied there was nothing suspicious and were not going to pursue the matter any further.

109. The investigator found no evidence that the man was assaulted on 8, 9 or 15 April. The current available information suggests that his bruising was the result of medical intervention. It is unfortunate that he thought that he had been assaulted which may well have caused him additional distress. Whilst I do not believe that he was injured by staff or prisoners, I am however particularly pleased that Spanish speaking prison healthcare staff went out of their way to see him and talk to him in his own language.

CONCLUSION

110. The man was remanded into custody on 30 May 2009. He initially complained about an ongoing cough which was attributed to his medication for a pre-existing heart condition. In addition, he had a chest x-ray that detected no abnormalities. He then developed swelling in his neck. He was seen by prison doctors and had a number of hospital admissions. Both agreed that the symptoms were due to an allergic reaction to his medication. However, when the swelling continued and he experienced a number of other symptoms, he was admitted into hospital on 1 March 2010, and later diagnosed with cancer of the lung.

111. The clinical reviewer concludes that his medical care in Winchester was appropriate. This was supported by my investigation. Given his limited English, good use was made of translation services and Spanish speaking medical staff. I was pleased to learn of the efforts to expedite his repatriation. However, his cancer was aggressive and his condition rapidly declined before he could return to his own country.

112. Although the use of restraints was generally proportionate and they were removed in the days before his death, I am disappointed that an escort chain was used during his transfer between hospitals without the benefit of a risk assessment when he was already so frail. I reflect this in my recommendations and also make a further recommendation aimed at improving timely cardiology referrals.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that arrangements are in place to make timely cardiology referrals where it has been identified that a prisoner is under the care of a cardiologist in the community.

   Accepted - Head of Healthcare to set up a system where anyone running a clinic will be given a sheet with the names of their patients on. They will tick for each one if there is a blood test, x-ray, prescription, referral etc. If there is a referral then they will say to what speciality and to which hospital. This will then be returned to HCC Admin Dept at the end of each day and these will be logged on the database. The referrer will then have 72 hours to dictate the letter and get it typed. It will then be logged when this was done, and then the sent date and how it was sent - e.g. fax, post, verbally arranged appointment, and when the appointment was booked for when it comes in, and then the final column can be completed when they have attended the appointment with the date (as sometimes it is rebooked as the hospital seem to send the letters to the in-mates sometimes as well) or there are escort issues, or if they have declined to go on the day (It will then be a role for HCC Admin Dept to chase the referrer if they haven' completed their part of the process by the end of the initial 72 hour period. This new system should prevent any outstanding referrals).

2. The Head of Security should review the arrangements for completing escort risk assessments for prisoners being transferred between hospitals.

   Partially accepted – All prisoners are re-risk assessed before and after transfer between hospitals. This was done although it has been felt by the PPO that the use of restraints were unnecessary. This recommendation will be considered for future escorts.

GOOD PRACTICE

1. A Spanish speaking prison nurse and doctor visited the man to help translate information relating to his diagnosis and treatment.