# Investigation into the circumstances surrounding the death of a man, in May 2010 at outside hospital, whilst in the custody of HMP The Mount

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

**November 2011**

This is the report of an investigation into the death of a prisoner at HMP The Mount. The man died in May 2010 at outside hospital, having been admitted 12 days earlier. He was 54 years old. The cause of death was found to be metastatic lung carcinoma (lung cancer). I offer my sincere sympathy and condolences to the man's wife and family, and to all who have been affected by his loss. I would like to thank the man's family for their contribution to the investigation. I am sorry that my report has been delayed and I apologise for the distress which this has caused.

The investigation was carried out by two of my colleagues. The man's clinical care in custody was reviewed by a clinical reviewer on behalf of West Hertfordshire Primary Care Trust. I am grateful to the clinical reviewer for her assistance with this matter.

I would also like to thank the staff of The Mount for their co-operation during the course of the investigation. My particular thanks go to the head of the offender management unit at The Mount for her assistance in liaising with the investigators.

The man's illness was only diagnosed ten days before he died. The clinical review into his care concludes that the actions of healthcare staff at The Mount were appropriate and were carried out in a timely manner. However, my report highlights several areas where improvements are needed and I make 13 recommendations, many of which relate to clinical care.

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.

**Thea Walton**
**Acting Deputy Ombudsman** **November 2011**

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## SUMMARY

At the time of his arrival at HMP The Mount in April 2009, the man had served around 13 years in various prisons in England. He had suffered back pain for many years, for which he took a strong painkiller (dihydrocodeine), and had been diagnosed with spondylosis (arthritis of the spinal vertebrae). On account of its status as a controlled drug (meaning that it is susceptible to misuse), the man was required to collect the dihydrocodeine each day, in line with the local policy at The Mount.

In the summer and autumn 2009, the man regularly failed to collect his dihydrocodeine. He indicated to healthcare staff that this was because he was trying to reduce the dose. Despite this indication and the frequency with which he did not collect his medicine, no medication review was forthcoming during this period. The clinical reviewer recommends that an appraisal is undertaken of the medication review process.

Towards the end of 2009 and into 2010, the man's pain began to increase considerably. His painkiller was changed and strengthened on a number of occasions over the following months. However, at no point did he consider that the medication was sufficient to control his pain. Blood tests taken at The Mount on 1 February 2010 showed nothing abnormal. When they were repeated in March, they showed indications of inflammation or infection. The man was subsequently referred to a rheumatologist and, at an appointment on 14 April, an x-ray showed nothing abnormal.

By this time, healthcare staff at The Mount thought that the man's health had deteriorated to the extent that he should move to a prison with 24 hour healthcare. It was subsequently arranged for him to move temporarily to HMP Bedford, where the man arrived on 19 April. During his ten days at Bedford, the man went to hospital for radiograph and MRI scans. Again, they showed nothing to explain his dramatic increase in pain.

It is apparent that the man's health had deteriorated further by the time he returned to The Mount. He was given crutches to help him walk and his friends on the wing collected his meals for him. The prison doctor told the investigator that the man's health on his return was worse than he had been led to believe. My report recommends that the healthcare manager establishes a more formal means of determining the health of prisoners before they return from prisons with 24 hour healthcare.

The man became more reliant on his friends in the days after his return to The Mount. There were no formal arrangements in place to provide assistance and he depended on the good nature of fellow prisoners. The clinical reviewer recommends a national review of the assessment and provision of social care for prisoners.

The prison doctor thought that the man might have cancer and made an urgent referral on 7 May. This followed the diagnosis of a possible deep vein thrombosis, as the man said his right leg had been swollen for around 24

hours. The doctor telephoned outside hospital to discuss admission that day, but was advised to follow the usual referral procedures.

Two days later, the man was admitted to outside hospital when his health had deteriorated further. After various tests at hospital, advanced cancer of the bowel and lung was diagnosed on 11 May. The man was released on temporary licence on 13 May, and died just ten days after diagnosis.

The man's family have asked whether his cancer could have been diagnosed earlier, particularly as he was in severe and worsening pain. Given his significant deterioration over a period of several months, I fully understand their concern. However, the clinical reviewer concludes that the actions of medical staff at The Mount were "timely and appropriate". She goes on to say that there is no clear evidence that the man's specific symptoms "should have precipitated an earlier referral to hospital".

Nevertheless, the report highlights several areas where practice might be improved and makes a total of 13 recommendations, many of which are taken from the clinical review. As well as those noted above, the recommendations concern areas including the timeliness and quality of risk assessments when a prisoner is in outside hospital.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 24 May 2010 when the investigators issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigators. Five prisoners came forward as a result.

2. The investigators first visited The Mount on 2 June. During the visit they met the Governor and a member of the local Independent Monitoring Board (a body of local people who independently monitor and report on the prison). They toured the establishment, including the healthcare centre and the wing where the man lived. The investigators also met one prisoner who was a friend of the man. In addition, they were given copies of the man's prison records.

3. The investigators returned to The Mount to formally interview staff and prisoners on three further occasions: 20 July, 27 July and 2 August. In total they interviewed eight members of staff and four prisoners during their visits. At the conclusion of the final visit they met the deputy governor to feed back the initial findings of the investigation. This was subsequently followed up in writing to the Governor.

4. A review of the man's clinical care whilst he was in custody was undertaken by a clinical reviewer on behalf of West Hertfordshire Primary Care Trust. She joined the investigators at The Mount on 27 July and participated in the interviews scheduled for that day. This included an interview with the prison doctor. Regrettably, the completed clinical review was not received until February 2011, leading to the delay issuing my own report.

5. One of my family liaison officers telephoned the man's daughter on 9 June. My family liaison officer explained the purpose of the investigation and gave the man's family the opportunity to ask questions or raise any concerns they might have. My family liaison officer and my investigators subsequently met the man's wife and daughters on 1 July.

6. During the meeting, the man's family raised the following issues that they wished the investigation to address:

    - Was the man's pain management appropriate and effective? His pain became more severe from October 2009 and they described it as "unbearable" for the last three or four months of his life. They were concerned that the man was given paracetamol to manage his pain as the hospital consultant told them he should not have been taking this if his liver was not functioning.

    - Could the man have been diagnosed with cancer earlier? Given his severe and worsening pain, should an earlier hospital referral have been made? His family said that the man presented with symptoms of

cancer, namely clubbed fingers and discolouring of the whites of his eyes, two months before diagnosis. His family said they were told by the hospital consultant that the cancer had developed 18 months previously; therefore how could it have been missed?

- When the man transferred to HMP Bedford, staff at Bedford were misinformed about his condition and the reason for the transfer.

- Were any tests carried out at Bedford that could have gone ahead at The Mount?

- Given the man's physical condition and pain, should he have transferred back to The Mount from Bedford?

- By April 2010, the man was unable to leave his cell due to his pain. Healthcare staff therefore attended his cell when they wanted to see him. If his condition was so serious, why was he not taken to hospital at this point?

- In the days before he was admitted to hospital, the man was put on a "30 minute watch", meaning that staff checked him every half hour. If he needed this level of care, why was he not admitted to hospital?

- Did wing staff, particularly the man's personal officer, notice any deterioration in his health and should they have done more to encourage healthcare intervention?

- The man had difficulty accessing the communal telephone on his residential unit as it was upstairs on a different landing.

- When the man was admitted to hospital on 9 May 2010, his family say that they were not notified in a timely manner.

- Restraints were used inappropriately when the man was in hospital.

7. I hope that my report clarifies any issues that might remain unclear for the man's family and helps them to better understand what happened in the time leading to his death.

8. The man's family and legal representative received a copy of the draft report as part of the consultation process. I am grateful for the time they have taken to consider the report and for the feedback provided. Their response to the investigation findings can be found on page 38, and additional comments have been included as appropriate in the report. Some issues have been more appropriately addressed outside of this report in separate correspondence with the man's family and legal representative.

**HMP THE MOUNT**

9. HMP The Mount, situated near Hemel Hempstead, initially opened as a Young Offenders' Institution in 1987. It is now a category C prison for adult males. (Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape.) The Mount holds up to 768 prisoners. The Brister residential unit, where the man lived, consists of four wings each with 28 single cells. Every prisoner on this unit has enhanced status on the local Incentives and Earned Privileges Scheme. (IEP is a three tier system designed as an incentive to reward good behaviour in prison. Incentives include access to in-cell television, more private cash to spend and more time out of cell.)

10. Healthcare services at The Mount are commissioned by West Hertfordshire Primary Care Trust. The healthcare centre is open from 8.00am to 6.30pm Monday to Friday and from 8.00am to 5.00pm at weekends. Prison doctors attend from a local practice. They provide seven sessions a week from Monday to Friday. An out of hours' service is provided through the Hertfordshire Urgent Care Services.

11. Her Majesty's Chief Inspector of Prisons last inspected The Mount in October 2009. The then Chief Inspector reported that the "quality and breadth of primary health services was generally good". She also reported that prisoners had "good access" to healthcare and that primary care services were "generally responsive" to prisoners needs.

12. The Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison) annual report for 2009-10 reported that healthcare staff offered "consistently good care". They added that prisoners often faced long waiting lists for external outpatient appointments.

13. This is the third death of a prisoner at The Mount since the Ombudsman began investigating all deaths in custody in England and Wales in April 2004. Both the previous deaths occurred in 2007, one of which was due to natural causes. The investigation found that the deceased received care which was equitable to what he might have expected to receive in the community.

## HMP BEDFORD

14. HMP Bedford is a local category B prison. (Category B prisoners are those who do not need maximum security conditions but for whom escape must be made very difficult.) It holds up to 506 adult male prisoners who are mostly remanded into custody from Luton Crown Court and magistrates' courts in Bedfordshire. The establishment also takes sentenced prisoners from the London prisons.

15. Health services at Bedford are commissioned and provided by Bedfordshire Primary Care Trust, which is an arms length organisation of NHS Bedford. There are three prison doctors at the establishment, covering 16 sessions a week. An inpatient unit accommodates up to 13 patients in nine single cells and a four man dormitory, which is staffed by nurses.

16. HM Chief Inspector of Prisons last inspected Bedford in March 2009. She reported that the overall standard of health services was high. She went on to say that most residents of the inpatient unit had mental health problems. All inpatients spoke highly to her of the care provided by health services staff.

17. The IMB annual report for 2008-09 commented that prisoners held in the inpatient unit were "treated with care and dignity throughout".

18. The Ombudsman has previously investigated two deaths at Bedford that were from apparent natural causes. The most recent of these, following the death of an older prisoner in April 2010, concluded that the man's many chronic conditions were treated appropriately. However, the report recommended a review of the use of care plans for older prisoners.

## KEY EVENTS

19. The man was born in Cyprus in 1956. At the age of ten, he moved to the United Kingdom with his family. The man left school when he was 16 and set up his own business. He was married with a son and two daughters.

20. The man was convicted of various offences in the 1970s and 1980s, for which he received fines and community service orders. He was remanded to custody to HMP Brixton on 31 October 1996 and was subsequently sentenced to 22 years imprisonment for a drug related offence. The court also made a significant confiscation order.

21. After a few days at Brixton, the man moved to HMP Belmarsh and, one year later, moved on to HMP High Down. In June 1999 he transferred to HMP Whitemoor, where he lived for seven years. The man lived at HMP Long Lartin and HMP Wandsworth over the next year and a half, before moving to HMP Wormwood Scrubs on 27 February 2008. Around nine months before this move, in May 2007, the man had had a chest x-ray which showed nothing abnormal.

22. At the time of his arrival at Wormwood Scrubs, the man had suffered back pain for over 15 years. In 2006, he had been referred to the pain clinic at outside hospital where he received advice on pain relief. He also saw a physiotherapist from the orthopaedic service. An x-ray of his spine later in the year showed minor spondylotic changes. (Spondylosis is arthritis of the spine and means there is some degeneration of the vertebrae and discs in the back. It is a condition that is normally age related.) Various different painkillers had been prescribed to try to counter the man's pain. When he transferred to Wormwood Scrubs, the man was taking dihydrocodeine (a painkilling medication known as a 'weak opoid', which is converted to morphine in the liver). The dose was one 60mg tablet to be taken twice a day.

23. As well as back pain, the man had been diagnosed with a hiatus hernia (where part of the stomach pushes into the lower chest through a hole in the diaphragm) and asthma. In addition to dihydrocodeine, he was prescribed simvastatin (to lower cholesterol), Gaviscon (for heartburn and indigestion) and a ventolin inhaler (for asthma).

24. Shortly after his arrival at Wormwood Scrubs, the man complained of pain in his abdomen and difficulty passing urine. He was referred to a urologist (specialist in the urinal tract). After outpatient appointments in April and July, the man was diagnosed with a urethral stricture (narrowing of the urethra, the tube through which urine passes from the bladder). It is not clear from his records what treatment, if any, was prescribed.

25. On 22 April 2009, the man moved to The Mount. His back pain and asthma were noted at a reception health screen with a prison nurse. The man's weight and blood pressure were taken, which were within the normal range. The following day, the man's notes were reviewed by a

prison doctor who re-prescribed his medication. With the exception of dihydrocodeine, the man was allowed to keep all of his medication 'in possession' (meaning that he was given a week or several weeks supply at a time to store in his cell and take as prescribed). In line with The Mount's local policy, as dihydrocodeine is a controlled drug, special safeguards are in place and he had to collect it every day from the healthcare centre.

26. The prison doctor first saw the man on 28 April. He noted the recent diagnosis of urethral stricture, and the man added that he had difficulty passing urine during the day but went to the toilet frequently at night. The prison doctor also noted that the man had been taking painkillers for his back for over 20 years. He asked for the man to be referred to the Department of Urology at a local hospital. A referral letter was subsequently sent to outside hospital a week later, on 5 May. In addition, the prison doctor prescribed a course of omeprazole (medication for heartburn and stomach acid).

27. A blood sample was taken for testing on 11 May. The results were all normal with no further action recommended. (There is no indication from the notes when this test was requested.)

28. The man saw a nurse on 11 June and said that he had a new pain to the centre of his back. He asked for his dose of dihydrocodeine to be increased again, saying that it had recently been decreased as he wanted to stop the medication ahead of his impending release from prison. The request was passed to the prison doctor who noted that the man had not been prescribed a higher dose at The Mount and was not due for release for three years. The dose therefore remained the same. The following day, a urine sample was taken for tests, which came back as normal with no action recommended.

29. Four days later, the man saw a nurse practitioner (a registered nurse who has completed an advanced nursing education and can prescribe some medication). He said that his back pain was worsening and asked for stronger medication. The man also said he had a cough and had been producing green phlegm for a few days. The nurse practitioner examined the man's chest and noted that there were respiratory crackles (sounds caused when air is forced through respiratory passages that are narrowed by fluid or mucus). She prescribed a one week course of three different medications; amoxicillin (an antibiotic used to treat chest infections), prednisolone (used to control conditions such as asthma) and promethazine (used for allergic reactions and as a sedative).

30. On 23 June, the man saw an unnamed locum doctor. The man still had a cough and, after examining his chest, the doctor concluded that his asthma had worsened. He prescribed a further course of prednisolone. On four occasions in the next three weeks, the man did not collect his dihydrocodeine from the treatment hatch.

31. The man's hospital notes indicate that he failed to attend an appointment at the Department of Urology at outside hospital on 2 July. (This appointment was, presumably, a result of the referral in May.) It is not clear why the man did not attend, although there is no appointment letter in his prison records. The hospital wrote that they would be happy to see the man were he to be re-referred. It does not appear from the records as though a further referral was made.

32. At an appointment with a nurse on 16 July, the man said he was breathless at times and continued to produce sputum (mucus expelled from the lungs) when he coughed. The nurse checked his clinical observations (including blood pressure, pulse rate and body temperature), all of which were within normal ranges. He also checked the man's peak expiratory flow rate (a test of how well the lungs are working). At a consultation with the prison doctor later that day, this reading was described as "satisfactory". The prison doctor concluded that the man had a chest infection and prescribed a further course of amoxicillin. Again, there were several occasions over the following month when the man did not go to the treatment hatch to collect his painkillers.

33. The man saw a further nurse on 1 September and said that he still had a cough. The nurse examined him and noted that he was "very wheezy". She noted that he was taking amoxicillin and prednisolone and made him an appointment to review his asthma. Later that day, the man's medication was reviewed by a locum doctor. He told the doctor that he sometimes did not collect his dihydrocodeine as he was trying to reduce the dose. The doctor explained that it would probably be better to prescribe a lower dose to take every day, but that the man should think about this. The man's response is not recorded, although he collected his medication more regularly over the following fortnight.

34. On 11 September, the man saw a second prison doctor for his scheduled asthma review. She noted that his asthma was "still worse" and prescribed a two week course of clarithromycin (an antibiotic). The man did not collect his dihydrocodeine on six occasions during the remainder of the month.

35. The man next saw the second prison doctor on 2 October. He reported problems with urinating similar to those of 28 April. The doctor noted that the appointment with the Department of Urology should be followed up. She also noted "says prob going out 22/10/09", although there is no indication where this information came from. There is no indication in the records that a urology appointment was received for this or any other date. The man also told the doctor that he was reducing his dose of dihydrocodeine and was noted to be "stable". It does not appear as though the dihydrocodeine prescription was reviewed and it remained one 60mg tablet twice a day.

36. A week later, the man went to the healthcare centre and told a nurse that he felt unwell. He was noted as being "sweaty and clammy" with a

wheeze on his chest. Shortly afterwards, the nurse spoke to the second prison doctor who prescribed a further course of amoxicillin and prednisolone. Over the following six weeks, the man failed to collect his medication on 19 occasions.

37. On 26 November, the man saw an unnamed locum doctor and complained of recent headaches, which he said were relieved by paracetamol. The doctor prescribed a one week course of paracetamol. The man also said he was taking dihydrocodeine for his back pain and had tried to wean himself off in the past. However, he said the back pain was now recurring. He did not collect his medication on six occasions in the following fortnight.

38. The man was prescribed a further course of amoxicillin on 10 December, by a locum doctor. He was noted as "coughing and wheezy" which was thought due to a chest infection. The man did not collect his dihydrocodeine on six further occasions during the remainder of the month. He was prescribed another five day course of paracetamol by a locum doctor on 24 December, although the reason for the prescription is not recorded.

39. In the first fortnight of January 2010, the man failed to collect his dihydrocodeine on just two occasions (11 January and 13 January). At an appointment with the prison doctor on 15 January, he said that he did not think that the 60mg dihydrocodeine tablets were sufficient for his back pain. The man also said he was experiencing some withdrawal symptoms, such as stomach cramps and headaches. The prison doctor changed the painkiller to tramadol 150mg, to take one tablet per day.

40. Six days later, the man saw a further nurse. He told the nurse that he felt nauseous in the morning since stopping dihydrocodeine. He went on to say that his back pain was no better since he started taking tramadol. An appointment was booked for the man to see a prison doctor on 26 January.

41. At the appointment with the prison doctor, the man described a number of symptoms which he had experienced since stopping the dihydrocodeine. They were all considered by the prison doctor as likely consequences of withdrawing from dihydrocodeine. He increased the dose of tramadol to 200mg per day and prescribed additional medications to counter the man's withdrawal symptoms.

42. The man did not collect his tramadol on each of the following three days. Blood tests were taken on 1 February, the results of which were all normal. Three days later, the man saw a further nurse and said that he had had a chesty cough for a few days. He said that he felt a muscular pain in his chest when he coughed and also brought up small amounts of light brown coloured sputum. The nurse examined his chest and noted that she could hear no wheezes or crackles. The man was breathing normally with no central chest pain. She noted that he was apyrexial,

meaning that he did not have a fever. The man was booked to see a nurse practitioner the following week for review.

43. At his scheduled appointment with a nurse practitioner on 11 February, the man said that he had had a cough producing brownish phlegm for ten days. The nurse practitioner prescribed a one week course of amoxicillin. (This was the last time that the man reported a cough or chest condition.) Over the remainder of the month, the man collected his tramadol on all but one day. The prison doctor prescribed a four week course of paracetamol on 25 February, although the reason for the prescription is not recorded.

44. On 2 March, the man saw a further nurse with regard to his back pain. He said that he had been unable to get out of bed over the weekend and the tramadol did not control his pain. The man said that he had thought about using heroin to control the pain but had resisted as he did not want to start using illicit drugs. (He explained that he had last used heroin in 2005.) The nurse made him an appointment to see a prison doctor.

45. The man subsequently saw the prison doctor on 5 March. He reported an increase in his lower back pain, and said the pain was now constant during the day and night. The man said the tramadol was ineffective, but that the pain had become worse before he changed from dihydrocodeine. The prison doctor examined the man and noted that all of his movement was limited by pain. He noted that there could be an "alternative reason/disease in back for pain". The prison doctor requested blood tests and noted that he would consider a referral for a scan.

46. At interview with the investigator, the prison doctor explained why he did not ask for a scan at this stage:

> "There are a number of appropriate blood tests that one needs to do [before a scan] if you're considering whether there may be another underlying problem here … [Some of these tests] don't look at any individual condition but if you have a major infection going on somewhere or a tumour of any other major inflammatory condition these tests will go up high so we use them in this instance as a mark to say we should be looking into this further.
>
> "Given that [the man] had 20 years of back pain and it's mechanical back pain it would be unreasonable to jump to the conclusion that there must be something serious going on here … It's about getting the priorities right in terms of the investigation."

47. Whilst awaiting the outcome of the blood tests, the prison doctor increased the man's dose of tramadol to 300mg per day. He also prescribed a course of naproxen, which is an anti-inflammatory medication used for treating conditions such as arthritis.

48. Ten days later, the man saw a locum doctor and repeated his previous complaint that tramadol did not provide adequate pain relief. The man

asked to resume taking dihydrocodeine, and the doctor agreed to prescribe a one week supply. The doctor also spoke to an officer on the man's wing, and found out that he worked as a wing cleaner. The officer told the doctor that the man could mop the floor and clean without a problem. It is not noted which officer the doctor spoke to. However, around this time the man's personal officer (each prisoner is assigned a personal officer whom they can approach first with any problems), noted in his history sheet that the man was struggling to perform his cleaning duties. The man's family commented that he was desperate not to lose his job and the privileges that came with it, a view that was shared by his personal officer at interview. The locum doctor instructed that the man should stop work immediately so as not to exacerbate his condition further. However, it appears that the man continued to work until he was signed off sick on 1 April.

49. The requested blood tests were taken on 18 March. The man saw the prison doctor on 22 March to review the results. He told the prison doctor that the pain remained and now extended to his right leg. The prison doctor increased the dose of dihydrocodeine to 120mg twice daily. The blood results showed raised inflammatory markers (measures of inflammation or infection).

50. As a result, the prison doctor referred the man to a consultant rheumatologist at outside hospital. At interview, the prison doctor explained as follows:

> "The results indicated he had a raise in inflammatory markers but without really very much else going on in the blood test, everything else appeared to be normal … I was concerned that we may be having a significant issue here or potentially a malignant issue but the symptoms and signs only pointed to this being an increase in back problem … I hadn't formulated a diagnosis because there wasn't enough information to go on … so I opted to refer to the rheumatologists on the basis that they would be able to access a scan quickly if we needed one."

51. The man next saw the prison doctor on 31 March, when he again said that he was in a lot of pain. He added that his new dose of dihydrocodeine was still ineffective. The prison doctor changed the painkiller to fentanyl 12mg patches. (Fentanyl is a strong painkiller and is applied using a patch for continuous pain relief. Patches are applied for three days at a time before being replaced.)

52. On the same day, an application for parole was refused by a panel of the Parole Board. The panel determined that the man had not reduced his risk of reoffending sufficiently to be managed safely in the community.

53. A week later, the man told the prison doctor that his pain was still increasing. The prison doctor increased the strength of the fentanyl patch to 25 mg and also prescribed a course of zopiclone (a sleeping tablet).

He also pursued the rheumatology referral and now requested that the man should be booked under a two week urgent cancer referral. (National referral guidelines for suspected cancer instruct that patients referred urgently should be seen by a specialist within two weeks.) The prison doctor wrote on the referral:

> "I remain concerned at the nature of this man's problem and can't exclude myeloma [a cancer that affects cells in the bone marrow] or similar malignant change affecting his back."

54. A further 28 day course of paracetamol tablets was prescribed on 8 April. Again, no reason is given in the notes to explain why this was prescribed. Later entries indicated that the man took the paracetamol for his back pain as and when he required it.

55. The appointment with the consultant rheumatologist took place on 14 April. An x-ray was taken, which showed nothing to explain the man's recent deterioration. The consultant said that he would arrange an MRI scan (magnetic resonance imaging is a scan that can provide pictures of organs and other structures in the body) for a future date to investigate the symptoms further.

56. Following his return from hospital, the man saw a nurse. He said that he felt numb and weak on his left side, and was concerned that he might have had a stroke. The nurse examined the man and noted that he showed no sign of FAST symptoms (the national guidelines for detecting whether a stroke has occurred). Nevertheless, she made an appointment for the man to see the prison doctor the following day.

57. At the appointment, the prison doctor noted that the man's numb feeling now only affected his lower lip. The man said that his pain was now better controlled but was still an issue. The prison doctor increased the strength of the fentanyl patches to 37mg.

58. The man's daughter told my family liaison officer that she spoke to her father on the telephone around this time. She recalled that he was very distressed throughout the call and said he "could not go on anymore because of the pain".

59. On 19 April, the man saw the prison doctor. His neck and arms were noted to be "jerking" and he said he felt short of breath, light-headed and had difficulty walking. The man said that the fentanyl was effective for two days but his pain got worse on the third day with the patch. The prison doctor thought that the man should move to a prison with a healthcare inpatients unit.

60. After discussion between the healthcare managers at The Mount and HMP Bedford, it was agreed to transfer the man for observation for a few days. At interview with the investigator, the prison doctor explained why he recommended this move:

> "He was getting to the point where in this prison he wasn't able to manage with the amount of pain that he was in. He was requiring help and support outside the hours that we had health staff to look after him … so I arranged for him to go to Bedford in order to avail ourselves of a 24 hour healthcare service."

61. The prison doctor also explained why he did not admit the man to hospital instead:

> "I considered it but actually it's not really appropriate. What we were looking for was for someone to look after this man in a nursing way until such time as he had his [MRI] scan and that's not what hospitals are for … I didn't try the hospital as I firmly believed they wouldn't have accepted him on that basis."

62. The man subsequently arrived at Bedford on the evening of 19 April and was allocated a cell in their inpatient unit. The following morning he was reviewed by a prison doctor. The prison doctor noted that the man had complained of spasms in his back, neck and left arm overnight and was unable to get out of bed without assistance. He was also noted to be "very confused". The prison doctor decided to admit the man to outside hospital for further assessment.

63. A radiograph (a specific type of x-ray) of the man's spine was carried out at the hospital, but found nothing abnormal. He was discharged back that evening, having been prescribed a course of temazepam to help him sleep at night. He was reviewed by the same prison doctor the following morning, who noted that they would prescribe diazepam (a sedative commonly known by the brand name Valium) as an alternative to temazepam. The prison doctor also noted that the man was "fit to return to The Mount", although he did not provide any further explanation.

64. Later that morning another prison doctor at Bedford spoke to the prison doctor at The Mount about the man's location. The prison doctor at Bedford explained their view that the man could return to The Mount. The prison doctor at The Mount's view, as he explained at interview with the investigator, was that it was beneficial for the man to be in an environment where he had access to care for 24 hours a day. The doctors agreed that the man could remain at Bedford a few days longer for further review. Later that day the second prison doctor at Bedford represcribed dihydrocodeine alongside fentanyl, as the man felt that fentanyl was ineffective. (The new dose of dihydrocodeine was two 30mg tablets four times a day.)

65. Over the following week, the man took his medication as prescribed. On some days he said he was in pain, but on others he appeared relatively settled. On 29 April, it was agreed that the man could return to The Mount the following day. This followed discussion between the prison doctor at The Mount and prison doctors at Bedford and between their healthcare

managers. The man's MRI scan was scheduled for the morning of 30 April and it was agreed that he would be taken back to The Mount afterwards.

66. The MRI scan found minor damage to some of the man's discs, but otherwise was unremarkable. On his return to The Mount that afternoon, the man was reportedly "very distressed" with pain. He went straight to healthcare from reception to see the prison doctor at The Mount. The man told him that he was in a lot of pain despite taking both fentanyl and dihydrocodeine.

67. The prison doctor at The Mount therefore stopped the course of fentanyl and instead prescribed a course of morphine (a strong painkiller), to take one 150mg tablet a day. (The morphine had to be ordered and could not therefore be dispensed straight away. The man continued to use fentanyl patches until morphine was available.) He also arranged for the man to be given crutches to help him walk. The doctor told the investigator at interview that the man was "in a worse state than … we were expecting" and suggested that staff at Bedford had underplayed the deterioration in his condition.

68. The man remained in pain over the following four days. The prison doctor and nursing staff began to visit him in his cell so that he did not have to walk over to the healthcare centre. The prescribed morphine was available on 4 May and the first dose was given to the man that afternoon. The following day the man told a nurse that the morphine worked well for 12 hours, and he asked for a second tablet per day so that he could be free of pain during the night as well. The nurse wrote that she would speak to the doctor about this, although there is no note of this conversation. She also noted that the man was able to walk a little, including going upstairs to use the telephone.

69. On 7 May, the man was visited by his mother and cousin. He was taken to the visits hall in a wheelchair. The man's family later told the investigator and family liaison officer that he was in a lot of discomfort and unable to walk. They also said that he was clearly jaundiced and had lost a lot of weight.

70. At a review with the prison doctor on the same day, the man said his lower right leg had been swollen for around 24 hours. The doctor diagnosed a possible deep vein thrombosis (DVT, a blood clot that forms in a vein, usually in the leg) and prescribed a course of enoxaparin (medication used to stop blood clots forming). The man repeated that his pain relief was not adequate for 24 hours and so the prison doctor increased the morphine dose to 180mg daily.

71. As a result of the man's symptoms, the prison doctor made an urgent referral under the two week wait for suspected cancer. The referral was sent to the Department of Urology at outside hospital. The prison doctor told the investigator that the reason for this referral was that the sudden

emergence of a blood clot might be related to a renal (kidney) tumour. He added that he telephoned the hospital with the intention of arranging for the man's admission that day. However, the prison doctor was advised to make a referral through the DVT clinic instead, with the likelihood that he would be seen the following week.

72. An entry by a nurse that evening noted that the man remained in pain and his mobility was poor. A nurse indicated that a wheelchair had been loaned to the wing for the man to use.

73. The following day, a nurse visited the man in his cell to give him his medication. He noted that the man was in pain and had lost his appetite. He went on to say that the man's mobility remained poor and he looked jaundiced. Later that afternoon, the nurse returned to see the man again. On this occasion he felt he seemed brighter and more alert, although he remained in pain.

74. On the morning of 9 May, two nurses visited the man in his cell, after wing staff expressed concern that he had had a "difficult night". The man's personal officer recorded that the man's health was giving them "great concern". The man told the nurses that he had pain in both of his legs. He was noted to have a swollen abdomen and that his skin colour was "slightly yellowish". The nurses also observed that he was "very distressed and agitated" with the pain. One of the wing officers said that they suspected that other prisoners had given the man heroin to use as pain relief, although he denied this.

75. As 9 May was a Sunday, no doctors were on duty at the prison. A nurse therefore telephoned the out of hours service for advice and was advised that an on-call doctor would visit. The doctor arrived later that morning and examined the man. She decided to admit him to hospital for further assessment of the cause of his swollen abdomen. An ambulance was called and the man was taken to outside hospital early that afternoon.

76. 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. In this case it was determined that the man would be accompanied by two officers whilst he was in hospital and cuffed to one of them by means of an escort chain (a long chain with a handcuff at each end). The escort becomes a bedwatch if it is determined that the prisoner will remain in hospital as an inpatient.

77. Over the following days, the man underwent various tests in hospital. On the morning of 11 May, it was confirmed that he had advanced cancer of the bowel and lung, which had spread to his liver. The man was told the news by a doctor at the hospital. That afternoon he was visited in hospital by members of his family. The man had told his family of his hospital admission over the telephone that morning. A revised risk assessment

completed that day concluded that there should be no change to the level of restraints or the number of bedwatch staff.

78. On the same day, the possibility of applying for early release on compassionate grounds was raised at The Mount. The hospital was contacted to inform them of the process and warn the doctors that they might be asked to contribute to the application.

79. The healthcare manager at The Mount visited the man on 12 May. She spoke to both the man and his family during her visit. The healthcare manager noted that the man told her that he did not want his family to know of his prognosis at this stage. She later asked the consultant to prepare a letter for an application for early release on compassionate grounds. She also asked that the prison consider release on temporary licence and removing the man's restraints. (Release on Temporary Licence [ROTL] is the process by which suitable prisoners are released from custody on a temporary basis in order to carry out specific activities that cannot take place in the establishment. There are three types of licence, including a compassionate licence which can be used for urgent medical treatment.)

80. A risk assessment completed on 13 May determined that the escort chain could be removed and the bedwatch reduced to one prison officer. Later that afternoon, the man was released on temporary licence on compassionate medical grounds. This meant that he no longer had to be accompanied in hospital by an officer. The man's family gave positive feedback about the officers carrying out the bedwatch on 13 May, and said they tried hard to keep his spirits up and engage with the family.

81. On the same day, the man was told that he might only have eight weeks to live. A letter outlining the man's diagnosis was subsequently prepared by a doctor at outside hospital. He wrote that the man had a diagnosis of metastatic lung cancer (metastatic means that it has spread to other organs) with a poor prognosis. He did not give a specific timescale, however, and commented that they awaited investigation results to determine whether the cancer might respond to chemotherapy or radiotherapy.

82. As the doctor at outside hospital did not give a definitive prognosis, staff at The Mount contacted the outside hospital and asked for a revised letter to be completed. This was subsequently written on 18 May by a doctor. The doctor noted that "… no curative treatment will be possible … we estimate a very poor prognosis".

83. The man's hospital notes indicate that the possibility of referring him to a hospice close to his family's home was raised on 19 May. The application for early release on compassionate grounds was sent by special delivery to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS) on the same day. A covering

email sent to PPCS confirmed that the man's prognosis was currently about eight weeks.

84. The ROTL licence prepared on 13 May expired at 4.30pm on 19 May. There is no evidence to indicate that a renewal was prepared. The man remained without an escort, as had been the case before the licence expired.

85. At 1.10pm on a day in May, with his family present, a nurse reported that the man had died. The time of death was formally certified by a hospital doctor as 1.30pm. The cause of death was recorded as metastatic lung carcinoma. A decision about early release was still being considered at the time. The Mount's family liaison officers visited the man's family on 23 May. They later attended his funeral, which was held on 25 May and to which the prison contributed costs. A prisoner who was friends with the man and his family was released on temporary licence for the day so that he too could attend the funeral. In addition, a memorial service was held at the prison which was attended by the man's family and 28 prisoners. The Mount's family liaison officers returned the man's property to his family on 3 June. The man's family spoke positively about the prison's family liaison officers and were appreciative of the opportunity to meet prisoners who knew him at the memorial service.

## ISSUES

### Urology referral

86. The man was referred to a urologist shortly after his arrival at Wormwood Scrubs, after complaining of pain in his abdomen and difficulty passing urine. Following outpatient appointments at outside hospital in April and July 2008, he was diagnosed with a urethral stricture.

87. When he saw the prison doctor on 28 April 2009, a week after he moved to The Mount, the man again said he had difficulty passing urine. The prison doctor noted the previous diagnosis and made a referral to the Department of Urology at outside hospital. (The referral letter is dated 5 May 2009.) The prison doctor described this as a "routine referral" as it is fairly common for an older man to have difficulty passing urine.

88. Hospital notes obtained by the investigator indicate that the man failed to attend an appointment at outside hospital on 2 July 2009. (It is presumed that this appointment was in follow up to the May referral.) It is not clear why he did not attend this appointment. On 2 October, at an appointment with a second prison doctor, the man again complained of difficulty passing urine. The second prison doctor noted that the urology appointment should be "chased". Again, there is no indication of any further contact with the Department of Urology. The man told the second prison doctor that he might be going to hospital on 22 October. It is not clear how he got this information and there is no indication that an appointment was ever arranged for this date. Even if this were the case, the appointment would have had to be rebooked as, for security reasons, prisoners are not permitted to know in advance when they are going outside the establishment.

89. The clinical reviewer notes:

> "There appeared to be no mechanism by which a referral to secondary care was routinely monitored by the prison healthcare team to ensure that the patient met their appointment. This is essential to ensure that the [national] 18 week wait from referral to treatment target is met."

90. There is no indication that the man saw a urologist at any time during his time at The Mount following the referral on 5 May 2009. The clinical reviewer subsequently makes the following recommendation:

**The healthcare manager should review the process for referring prisoners to secondary healthcare. This should include a record of when prisoners are referred, the date of their appointments, who they see and what the outcome is.**

**Pain management**

91. The man's family asked whether his pain management was appropriate and effective. They were concerned that his pain became more severe in October 2009 and was "unbearable" for the last three of four months of his life. The man's family were also concerned that he was given paracetamol for his pain, as a hospital consultant had told them he should not have taken it if his liver was not functioning.

92. The man had suffered back pain for over a decade and, at the time of his move to The Mount, was taking dihydrocodeine, a strong painkiller. His prescriptions are detailed in the clinical review and changes to his painkiller are described in the 'Key Events' section of this report. In summary, the man's painkiller was changed to tramadol in January 2010, with the dosage increased in late January and early March. In late March he reverted to dihydrocodeine, but at double the previous dose. This was supplemented with a fentanyl patch at the end of March, with the strength of the patch increased in April. In early May, the patch was replaced by morphine tablets.

93. From June 2009 onwards, there were a number of occasions on which the man did not collect his daily dose of dihydrocodeine. He told a locum doctor in September that this was because he was trying to reduce the dose. The doctor advised the man that they should therefore reduce the dose he was being prescribed and that he should think about this.

94. Over a six week period in October and November, the man did not collect his dihydocodeine on 19 occasions. In late November, he told a locum doctor that he had tried to wean himself off dihydrocodeine in the past, but his back pain was now returning. Nevertheless, the man continued to miss his medication on a number of occasions until his prescription was changed in mid January 2010.

95. It was the man's right to decide not to collect medication and the choice of whether to take the painkiller was entirely his. Nevertheless, the frequency with which the man chose not to take dihydrocodeine over this period of several months is unusual. It is therefore surprising that no formal medication review took place over the period, especially considering that the man suggested on several occasions that he wished to reduce the dose of his painkiller. The clinical reviewer agrees and notes that "this non-attendance should have triggered a medication review".

96. From mid-January 2010, the man began to say regularly that his medication was not sufficient to control his pain. This led to the changes in dosage and medication described previously and, from this point, the man began to collect his medication on a much more regular basis. At no point through the rest of his time in prison was the man consistently satisfied that his pain was fully controlled by his prescribed medication. I am surprised that he was not referred to a pain management specialist.

**NHS Hertfordshire should review the pathway for pain management for prisoners in The Mount, which should reflect the service that is available in the local community.**

97. From speaking to staff and prisoners there is some suggestion that the man was given heroin by other prisoners to supplement his painkillers. The man was asked about this at one stage, but denied the suggestion. The Governor is aware of these allegations and will, I trust, investigate as he sees fit. However, given these suggestions, it might have been worthwhile undertaking tests to determine whether the man had taken illegal drugs.

98. The clinical reviewer notes that, were the man taking illegal drugs, "this would have complicated the doctor's ability to establish the source of pain and provide adequate pain relief". She also comments on the difficulties of managing highly tradable medications (such as dihydrocodeine or tramadol) in a prison such as The Mount that does not have 24 hour nursing cover to administer such drugs overnight. The clinical reviewer adds that it was this issue that led to the change to fentanyl patches, although the change "did not appear to be supported by a thorough clinical examination".

99. The clinical reviewer comments and recommends as follows:

> "Medication reviews were recorded several times in the prison clinical record as undertaken but it is unclear what the mechanism was, whether or not the patient was present and what the objectives were."

**The healthcare manager should evaluate the medication review process which should include consideration of who undertakes reviews, when they are undertaken, what information is given and how they are documented (consideration could be given to developing a template). The review should also include a process for triggering a review of prisoners who do not collect their daily medication.**

100. The man was first prescribed paracetamol at The Mount on 26 November. This was a short course provided when he complained of recent headaches. Further courses of paracetamol were issued in December 2009 and February and April 2010. The reason for the later prescriptions was not explicitly or contemporaneously recorded in the man's medical record. Later entries indicate that it was given to supplement the medication for his back pain, so that he had an additional painkiller available to take as required through the day and night.

101. The man's family were concerned that he was given paracetamol, as a hospital consultant has told them that he should not have taken this medication if his liver was not functioning properly. However, this medication was prescribed before the liver condition was diagnosed. The

clinical reviewer notes that the man was given paracetamol for breakthrough pain (meaning pain that comes on suddenly for short periods of time and is not alleviated by the patient's normal medication). She concludes that it is normal to use paracetamol in such circumstances.

**Timeliness of the man's diagnosis**

102. The man's family questioned whether his cancer could have been diagnosed earlier, as they were told by a consultant that it had developed 18 months before he died. They asked if an earlier hospital referral could have been made given his severe and worsening pain. They also suggested that he presented with certain signs of cancer, such as clubbed fingernails and discolouring of the whites of his eyes, several weeks before he was diagnosed.

103. From June 2009 until February 2010, the man was diagnosed on a number of occasions with chest infections or exacerbations of his asthma. He was usually prescribed antibiotics. The clinical reviewer considers that he was "treated appropriately" for these conditions.

104. As I have previously noted, the man began to complain regularly of increased pain from January 2010 onwards. Blood tests were taken on 1 February, which showed nothing abnormal and no further action was required. A month later, on 5 March, the man told the prison doctor that his pain had increased and it was noted that his movement was now limited due to the pain. The prison doctor considered at the time that there might be an alternative disease behind the increase in pain and requested more blood tests. At interview, the prison doctor explained that this is the first step that one would take to determine any underlying cause of the increased pain (see paragraph 45). However, the requested samples were not taken until 18 March, nearly two weeks later. The clinical reviewer makes the following recommendation:

**The healthcare manager should review the arrangements for pathology and blood tests, including requests and results, to ensure that they are obtained in a timely manner. This should include a review of the mechanisms for patients getting results from such tests.**

105. The results of this blood test were reviewed on 22 March, and showed raised inflammatory markers. The prison doctor therefore referred the man to a rheumatologist at outside hospital. On 7 April, the man told the prison doctor that his pain was still increasing. The prison doctor subsequently followed up the referral and now requested that it be booked as a two week urgent cancer referral. On the referral, the prison doctor explained that this was because he was suspicious that the increase in pain might be due to cancer of the bone marrow.

106. The rheumatology appointment went ahead on 14 April. An x-ray taken showed nothing abnormal and the consultant therefore arranged for the

man to return for an MRI scan at a later date. A radiograph at outside hospital on 20 April also showed nothing abnormal. The MRI scan was arranged for 30 April and, again, showed nothing unremarkable.

107. The prison doctor made an urgent referral under the two week wait for suspected cancer on 7 May. This followed his diagnosis of a possible DVT when the man reported that his right leg had been swollen for around 24 hours. The prison doctor explained that the reason for the referral was that a blood clot might be related to a kidney tumour. He telephoned the hospital to discuss admission that day, but was advised that urgent admission was not necessary and he should proceed through the usual channels instead.

108. Two days later, the man was admitted to outside hospital when his condition deteriorated further. After various tests at hospital, cancer was diagnosed on 11 May. Sadly, the man died just ten days later.

109. The man regularly saw healthcare staff throughout his time at The Mount. In his last few weeks he was seen almost every day. At no point did he mention having clubbed hands or fingernails or discoloured eyes, and these symptoms were not noticed by healthcare staff. His personal officer told the investigator that she first noticed the man looking "yellow" before he moved to Bedford and that, within a week of his return, he looked "dramatically worse". An officer who also knew the man on Brister wing, first noticed that he looked this colour "just before he went into hospital [on 9 May]". It was first recorded by healthcare staff that he looked jaundiced on 8 May. The following day, the man was admitted to hospital.

110. In summary, various tests and scans were carried out in the weeks leading up to the man's diagnosis. Other than the blood test of 18 March, none of them highlighted anything abnormal. At interview, the prison doctor explained why he did not seek to admit the man to hospital at an earlier stage:

> "The difficulty is always when you're working in real time it's actually knowing at what point when somebody's deteriorating does it become right that admission has to happen … I think the difficulty is that there was a significant deterioration and everything that we had in terms of investigation wasn't really pointing in that direction until 6 or 7 May, when there was a very clear deterioration which kind of screamed at you that there must be a big problem here, that this man's probably got cancer."

111. The clinical reviewer considers these referrals and the timeliness of the man's diagnosis, and concludes as follows:

> "The actions were timely and appropriate. There is no clear evidence to suggest that the signs and symptoms the man was exhibiting should have precipitated an earlier referral to hospital. It is unlikely that he would have been managed any differently in general practice in the

community … It is common for cancer not to produce any symptoms until it is well established and spread to other organs. In the community there are many cases of lung cancer that are not detected until they are well advanced."

112. The clinical reviewer makes a number of additional recommendations in her report. The Governor and healthcare manager will no doubt wish to familiarise themselves with them. However, this report limits itself to those recommendations which are particularly pertinent to the man's death and I do not therefore reproduce the clinical review recommendations in their entirety.

**Transfer to HMP Bedford**

113. The man's family suggested that staff at Bedford were misinformed about his condition and the reason for his transfer to the establishment. They also questioned whether any tests were carried out at Bedford that could have gone ahead at The Mount. The man's family also noted their view that The Mount would benefit from 24 hour healthcare to assist prisoners.

114. At interview, the prison doctor explained why he felt it prudent for the man to move to Bedford on 19 April:

> "He was getting to the point where in this prison he wasn't able to manage with the amount of pain that he was in. He was requiring help and support outside the hours that we had health staff to look after him … so I arranged for him to go to Bedford in order to avail ourselves of a 24 hour healthcare service."

115. Prior to the move, both the prison doctor and the healthcare manager at The Mount discussed the man's needs with the healthcare manager at Bedford. It was agreed that he would move for a few days for observation. The healthcare manager explained at interview:

> "If we've got somebody that requires 24 hour healthcare, but not hospital care, we tend to use Bedford, it's our local prison … We discuss our prisoners' needs with them and then they would accept or not."

116. The healthcare manager went on to say that there is no policy or protocol in place with Bedford to formalise these arrangements. The prison doctor explained that he considered hospital admission rather than a move to Bedford, but felt that the man's needs at the time were not appropriate for hospital admission and that he would not be accepted.

117. The man arrived at Bedford on the evening of 19 April, and was allocated a cell in the healthcare inpatients' unit. The following morning he was admitted to hospital by a prison doctor on account of symptoms including back spasms and confusion. The man was discharged later the same

day. He had a scan at hospital which showed nothing unusual, and was prescribed some sleeping tablets.

118. The following morning (21 April), the prison doctor at Bedford spoke to the prison doctor with a view to sending the man back to The Mount. The prison doctor at The Mount argued that the man should stay for a few more days for observation. He stayed at Bedford for another nine days. During this time, the man was seen every day by doctors and/or nursing staff. No specific tests were carried out at Bedford.

119. However, despite the man's complex care needs, there is no evidence to suggest that a care plan was opened at Bedford. Prison Service Standard 22, 'Health Services for Prisoners', provides the following guidance for prisoners' living in a healthcare inpatient facility:

> "Each patient has a named doctor and healthcare worker and a care plan. The plan is initiated within 24 hours of admission [to the prison's inpatient facility] and reviewed within one week in consultation with the patient and named healthcare worker."

120. The clinical reviewer considers the man's transfer to Bedford and comments:

> "The review found no evidence that the staff at Bedford were misinformed about his condition. There was evidence that both the general practitioner and the nursing staff at The Mount had spoken at length with staff at Bedford about [the man]."

121. However, the clinical reviewer makes the following recommendations to Bedford:

> **The healthcare manager at HMP Bedford should develop and agree a clear protocol for the acceptance of prisoners from other establishments, which outlines the level and limit of care available within the prison inpatient facility. The decision making process for admission should be clinically driven and identified in the service specification for HMP Bedford and NHS Bedfordshire.**
>
> **The healthcare manager at HMP Bedford should ensure that all patients have a baseline nursing assessment and a care plan initiated on admission to inpatients.**

**Return to HMP The Mount**

122. The man's family questioned whether it was appropriate for him to return to The Mount from Bedford, given his poor physical condition and pain levels at the time. The prison doctor confirmed at interview that the intention when he went to Bedford was that the man would return to The Mount. His return was first raised on the man's second day at Bedford, but it was agreed following discussion between doctors at the respective

establishments that he should stay a few days longer at Bedford to be reviewed.

123. The return was agreed on 29 April, again following discussion between doctors and healthcare staff at the respective establishments. It was noted that the man's medication was stabilising his pain. He arrived at The Mount in the afternoon of 30 April, having returned via hospital where he had his scheduled MRI scan.

124. On his return to The Mount, the man was described as "very distressed" due to his pain. His mobility had deteriorated and the prison doctor therefore asked that he be given crutches to assist with walking. The prison doctor commented on the man's condition on his return at interview:

> "I don't think Bedford were entirely truthful about the position with him when they sent him back and I think they were making light of his position. When we saw him he seemed to be in a worse state than we'd anticipated from what we were expecting."

125. Although it is clear that there was discussion between healthcare professionals at The Mount and Bedford ahead of the man's return, it is apparent from the prison doctor's comments that he considered that the man's condition was worse than had been described. It would be helpful to have a more formal means of preparing for the return of a prisoner from an establishment with 24 hour healthcare. With hindsight, my own view is that it is surprising that the man returned to The Mount given that he had clearly deteriorated in the ten days he spent at Bedford. He was still in pain and seemed unlikely to improve. Being in a prison with 24 hour healthcare would seem to be a sensible precaution.

**The healthcare manager should establish an assessment form, for completion at the sending establishment, to determine the needs and condition of patients ahead of their return from a prison with inpatient facilities.**

**The man's health following his return to The Mount**

126. The man's family commented that his health deteriorated at this point to the extent that he was unable to leave his cell and had to be visited by healthcare staff. They asked whether he should have been admitted to hospital at this time if his condition was so serious.

127. The first recorded occasion when the man was visited in his cell was on 3 May. He told a nurse that he did not think his painkillers were working. The following day the man was visited in his cell by the prison doctor and, later, given his first dose of morphine (which had been on order since 30 April). On 5 May, the man saw the nurse again and it was recorded that he was "mobilising a little", including going upstairs to use the telephone.

128. On 7 May, the prison doctor diagnosed the man with a possible DVT. He contacted outside hospital that day with a view to arranging admission, but was advised to follow the usual referral procedures. Two days later he was taken to hospital by ambulance as his condition had deteriorated further.

129. The clinical reviewer considers that, in the community, the man's symptoms "would not normally be a reason to admit to hospital". She goes on to say that support would normally be provided through the patients' home, through community nursing services or social care.

130. As far as the hospital was concerned, the man was in the equivalent to being in the community. Visits by healthcare staff to his cell to administer the controlled drug would be seen as the equivalent to a district nurses' visits. I can understand his family's worries but am satisfied that healthcare staff at The Mount had referred him to hospital and that hospital staff did not think that admission was necessary.

**Provision of social care**

131. The man's family also expressed concern about his mobility and said that he had difficulty accessing the telephone on his wing as it was upstairs on a different landing. They also said he was put on a '30 minute watch' before being admitted to hospital. His family questioned whether wing staff noticed any deterioration in the man's health and if they could have done more to encourage healthcare intervention. The man's family thought that there was a divide between healthcare and discipline staff at The Mount and that this was detrimental to the care he received.

132. There is substantial evidence to indicate that the man's mobility and ability to care for himself deteriorated, particularly following his return from Bedford. By now he had been given crutches to help him walk. Some of the man's fellow prisoners told the investigators that they collected food for him and helped him to have a bath as he was unable to use the showers. They added that the man found it difficult to walk and sometimes needed support from his friends to do so. I also note that he was visited in his cell by healthcare staff in his last week at The Mount.

133. The man's personal officer told the investigator that the man was noticeably worse following his return from Bedford. She said he was unable to carry a tray due to using crutches and therefore his friends collected his meals for him. The man's personal officer also said that the man's friends helped him get in and out of the bath, although she was unaware that he had problems getting to the telephone. She added that relations between wing officers and healthcare were good, and that when she had contacted healthcare to say that the man was in pain they came to see him quickly.

134. The investigator was given access to the recordings of the man's telephone calls made in the last week of his life. His calls were not

monitored and their content would not have been known unless he spoke to staff about his concerns. In these calls, the man told his family that he found it hard to walk and felt weak. He also said that he found it hard to get to the telephone but could manage with the help of his walking stick. The man also confirmed that he was taken to his visit on 7 May in a wheelchair.

135. There is only anecdotal evidence that the man was subject to extra supervision before his hospital admission. During a telephone call on 9 May, the man himself told his wife that he had been checked every half an hour the previous night. He was admitted to hospital later that day. None of the staff spoken to during the investigation were able to confirm these arrangements, although several had heard that this might have been the case. In addition, the investigator saw no written evidence to confirm that such supervision took place. If staff had thought that the man needed extra supervision overnight, then both the reasons for supervision and an ongoing log of events should have been recorded. It is not usual for prisoners to be checked so often and I am surprised that no records were kept.

136. It is clear that the man needed help with everyday tasks towards the end of his time at The Mount. There were no formal arrangements in place at The Mount to provide this assistance. It seems that it was generally left to his friends to help the man as best they could. The healthcare manager told the investigator and clinical reviewer that there are strong links to the community social care services. Occupational therapists and specialist nurses can come in to see prisoners if necessary. However, as the clinical reviewer notes, at no time was any assessment made of the man's social care needs or a referral made to community specialists. The clinical reviewer goes on to note that there is no internal provision for social care needs at The Mount.

137. I think that it is poor practice for prisoners who require help with everyday tasks to have to rely on other prisoners to provide assistance via their own informal arrangements. The clinical reviewer subsequently makes the following recommendations:

**National guidance should be agreed and developed to facilitate the assessment of social care needs of prisoners and provide care to meet the needs.**

**The healthcare manager should develop robust links with social services and ensure that social care needs assessments are undertaken when appropriate.**

**Use of nursing care plans**

138. I have described earlier how the man's medication was changed regularly to try to control his increasing pain. He had various other long term

medical conditions, including asthma. It is also apparent that he had a number of social care needs, particularly towards the end of his life.

139. The clinical reviewer notes that the man did not have a care plan for any of his nursing needs. Such a document would formally set out what interventions healthcare staff will deliver and what the patient could be expected to do for himself. Although I have no doubt that the doctors and nurses at The Mount acted with the best of intentions, the act of drawing up a nursing care plan should have focussed attention on the man's ongoing condition and his apparently unmet needs. Regular reviews would have ensured that he was monitored and the plan adjusted as necessary.

**The healthcare manager should ensure that care plans are in place for all prisoners with long term conditions or nursing needs.**

**Informing the man's family of his admission to hospital**

140. The man's family said that they were not notified in a timely manner when he was admitted to hospital on 9 May. They were told by the man himself when he telephoned them from the hospital on the morning of 11 May. The man's family visited him that afternoon and were regular visitors for the remaining few days of his life.

141. Good communication with a prisoner's family at such an emotional time can provide support and comfort. I appreciate that it can sometimes be difficult to balance security and concern for the rights of family and friends, especially during an admission to hospital. I also appreciate that prisons do not automatically notify next of kin when prisoners are taken to outside hospital for treatment. To do so for minor ailments or pre-arranged appointments would be disproportionate. It might also increase the risk of a prisoner escaping and be a threat to public safety. However, I do not consider that these provisos applied to this man. When a prisoner is admitted as an emergency or for a significant condition, I think that his next of kin should be informed at the earliest opportunity.

142. An escort risk assessment form is used at The Mount to determine the level of security required when a prisoner leaves the establishment. The form contains the instruction that a new risk assessment should be carried out within 24 hours of a hospital escort becoming a bedwatch. (The escort becomes a bedwatch if it is determined that the prisoner will remain in hospital as an inpatient.) The following instruction is also included:

> "Consideration also needs to be given to how and when close family members are informed of the prisoner being on a bedwatch and this should be recorded as part of the [new risk] assessment."

143. However, a new risk assessment was not completed until 11 May, two days after the man had been admitted. By this time the man had telephoned his family and told them that he was in hospital. It is

disappointing that he had to do this himself. Had someone from the prison contacted the man's family, the information would have helped to convey that his health was a matter of proper concern to the establishment.

**The Governor should ensure that a new risk assessment is produced within 24 hours of a hospital escort becoming a bedwatch. This should include consideration of when and how to inform the prisoners' next of kin that he has been admitted to hospital.**

**Use of restraints in hospital**

144. The man's family were concerned about the use of restraints in hospital. They thought it inappropriate that restraints were still in place after the man had been told that he was terminally ill when his mobility was already poor.

145. On admission to hospital, the man was accompanied by two officers and cuffed to one of them by means of an escort chain. The Head of Operations at The Mount told the investigator that this is the normal arrangement for prisoners in hospital. I have noted above that a new risk assessment was not completed within 24 hours of the escort becoming a bedwatch, as it should have been.

146. A new risk assessment was completed on 11 May, but no changes were made to the level of restraints. A further risk assessment was completed on 13 May, and concluded that the escort chain should be removed and escort reduced to one officer.

147. At the time of his hospital admission, the man had been in considerable pain for some time. His mobility had declined significantly and he needed the help of crutches to walk. On the morning of 11 May, the man was told that he had advanced cancer. There is no information regarding this diagnosis or any assessment of the man's health on the risk assessment completed that day. Each form has a section to be completed by healthcare staff. The healthcare section completed on 11 May contains the note, "currently on bedwatch located at [outside hospital".

148. The Head of Operations at The Mount authorised the risk assessment of 11 May. He told the investigator that he did not know if he completed the form before or after the man's diagnosis was confirmed. The Head of Operations recalled that he had "very little" information regarding the man's medical condition. He thought it unlikely that he was aware of the diagnosis as otherwise it would have been recorded on the assessment. He added that his principal consideration for the assessment was the man's sentence length and adjudication history (adjudications are prison disciplinary hearings).

149. The Head of Operations went on to say that a prisoner being diagnosed as terminally ill is a significant event and would have a bearing on the level

of risk. He said that he would expect to have been told this information by a member of the healthcare staff.

150. As I frequently reflect in my reports, the decision on whether to restrain a prisoner in hospital is a difficult one. The balance between decency and security can be hard to judge. The man was an ill man with poor mobility who had been diagnosed with a terminal illness in an advanced stage. Given his condition, I judge that the restraints should have been removed and the presence of the bedwatch officers would have provided sufficient security at this time. Such a decision might well have been reached had news of his diagnosis been better communicated within the prison.

**A full risk assessment, including an assessment of the use of restraints, should be prepared when a prisoner in outside hospital receives a significant change in circumstances. This should include a full consideration of the prisoners' diagnosis, prognosis and level of mobility.**

**Potential release from custody**

151. Following the man's diagnosis on 11 May, the prospect of submitting an application for early release on compassionate grounds was raised at The Mount. This is a permanent release on licence, usually on medical grounds, and any decision to grant early release can only be made by the Minister responsible. The criteria for early release are set out in Prison Service Order (PSO) 6000:

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
- the risk of re-offending is past; 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.

152. Paragraph 12.4.1 of PSO 6000 provides the following guidance to applicants:

> "Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy."

153. The man was given a prognosis of around eight weeks on 13 May. On the same day, release on temporary licence (ROTL) was approved by the Governor of The Mount. This is a temporary release from custody and

allowed the man to remain in hospital without the presence of escorting prison officers. It could not have been foreseen that he would die just over a week after being diagnosed. This was a considerate and speedy response by prison and healthcare staff at The Mount, with the intention of allowing the man to die with dignity and privacy and in the presence of his family. However, as I will discuss later in this report, the man's ROTL licence expired at 4.30pm on 19 May and does not appear to have been renewed.

154. A letter outlining the man's diagnosis was completed by a doctor at outside hospital on 13 May. However, this letter did not contain the definitive prognosis required by PSO 6000. Staff at The Mount therefore contacted the hospital to ask for a revised letter. This was completed by a further doctor on 18 May, although the letter again did not contain a specific outline of the man's life expectancy. Nevertheless, the application for early release was submitted to NOMS on 19 May, with a covering note confirming that the man had been given a prognosis of around eight weeks.

155. PSO 6000 notifies applicants that, "a decision will usually be made within two weeks, but more quickly if the circumstances require it". The man's health deteriorated significantly only a few days later and he sadly died before a decision could be made with regards to his release.

**Release on Temporary Licence**

156. As I have noted above, the man was released on temporary licence on 13 May. The initial licence expired at 4.30pm on 19 May. Given that the man's condition had not improved and there was no indication that the terms of his licence had been breached, I would expect the licence to have been renewed shortly before expiry. However, there is no evidence to indicate that a renewal was prepared.

157. The man remained in hospital under the same circumstances as when his licence was valid. I am satisfied that the apparent failure to create a new licence was a procedural oversight and there was no intention that the man should be escorted in hospital or returned to custody. However, as no new licence was produced this could mean that, technically, the man was unlawfully at large for the final two days of his life.

**The Governor should ensure that all prisoners in outside hospital who are released on temporary licence have a valid and up to date licence at all times.**

158. PSO 2710 instructs that, following a death in custody, "the establishment must promptly notify the coroner by telephone". When the man died he was considered to be released on temporary licence. Therefore the instructions of PSO 2710 would not apply. However, given the proximity of the man's death to his release on licence it would have been prudent to inform the coroner so that he might determine what action he wished to

take. Although I make no recommendation, the Governor should ensure that the coroner is notified in similar future circumstances.

**Support to staff following the man's death**

159. The man's personal officer told the investigator that she heard about his death on the "prison grapevine". The officer said that she was not offered support following the man's death, and thought this might have been helpful as he was a prisoner who she knew well.

160. PSO 2710 sets out that each prison must have an operational care team and plans in place to activate that team following a death in custody. I consider it essential that staff are provided with proper support following a death in custody. Not least, this is part of the employer's duty of care to its staff. It is unfortunate that the man's personal officer was not offered the support of the care team. Although the time that the man had been in hospital and released on temporary licence might have been a contributing factor, staff and prisoners knew him well and would have appreciated the support.

**The Governor should ensure that staff are offered the support of the care team following a death in custody. This should include those instances where the death occurs in outside hospital.**

## FAMILY RESPONSE TO THE DRAFT REPORT

161. I received a number of comments from the man's family on the draft report, some of which I discuss below. I have incorporated other comments into the report at the appropriate point, with additional issues addressed in separate correspondence. I hope that my comments help to clarify any outstanding issues that the man's family might have.

162. The man's family commented that he was diagnosed with metastatic lung cancer and bowel cancer. They suggested that the man's bowel cancer might have been detected earlier and, had this been the case, his chances of recovery would have greatly improved.

163. Following his admission to outside hospital, the man was diagnosed with metastatic lung cancer (meaning cancer of the lung that has spread to other parts of the body). His hospital notes indicate that the cancer had spread to the small bowel. I have earlier noted that a number of tests and scans were carried out in the weeks leading up to the man's diagnosis. Other than a blood test of 18 March, none of these procedures highlighted anything abnormal. The clinical reviewer concludes that the actions of prison healthcare staff were timely and appropriate with regard to the timeliness of referral. She adds the man would most likely have been managed in the same manner had he been living in the community.

164. The man's family also said they were concerned about the prison doctor's conduct. They specifically referred to the events of 7 April 2010, and said they were not satisfied with the prison doctor's answers in relation to why he did not take swifter action to ensure that the man received treatment or further investigation. As I have noted in paragraph 53, the prison doctor requested that the man be seen under the two week rule for suspected cancer. The man subsequently saw a consultant rheumatologist one week later. I agree with the clinical reviewer's view that this referral was appropriate.

## CONCLUSION

165. The man had suffered from back pain for over a decade which began to increase considerably in late 2009 and into 2010. Given the severity of the increase, it is quite understandable that his family are concerned that cancer was diagnosed just ten days before he died. In the weeks before diagnosis the man underwent various tests and scans, none of which were able to explain his significant increase in pain. The clinical reviewer is satisfied that the actions of medical staff at The Mount were appropriate given the symptoms which the man was exhibiting.

166. The clinical reviewer adds that there are "very few areas where [the man's] care was fundamentally different to that received in the wider community". Nevertheless, there are several lessons that could be learned from this investigation. In particular, it is disappointing that the man relied on help from his fellow prisoners when his mobility declined, rather than there being formal arrangements in place to assess and provide assistance.

167. Notwithstanding the many months of pain which the man experienced, when eventually he was admitted to hospital, I am pleased to learn that prison staff took prompt action to arrange for him to be released on temporary licence. This meant that he passed away with his family beside him and without the indignity of restraints or the presence of prison staff.

## RECOMMENDATIONS

1. The healthcare manager should review the process for referring prisoners to secondary healthcare. This should include a record of when prisoners are referred, the date of their appointments, who they see and what the outcome is.

   Accepted - A review of secondary care referrals to include West Herts Hospital Trust (WHHT) and NHS Hertfordshire Commissioners for Primary care. New systems are in place for recording of referred prisoners, referral speciality, appointment dates changes, and outcomes.

2. NHS Hertfordshire should review the pathway for pain management for prisoners in The Mount, which should reflect the service that is available in the local community.

   Accepted – Nursing and medical staff at HMP The Mount have access to specialist palliative care services (this includes the community palliative care consultant, lymphoedema treatment, psychological support, carer support). This team will assist and advise in the development of pain management and end of life care planning. In addition, urgent referrals can be made to the duty Macmillan nurse, a five day a week service 8.30am-5.00pm and 9.00am-5.00pm weekends and bank holidays. The nursing team at HMP The Mount also have direct access to Hertfordshire Community Trusts District Nursing Team. The above options are consistent with the wider community of Hertfordshire.

3. The healthcare manager should evaluate the medication review process which should include consideration of who undertakes reviews, when they are undertaken, what information is given and how they are documented (consideration could be given to developing a template). The review should also include a process for triggering a review of prisoners who do not collect their daily medication.

   Accepted – Processes to be discussed at the next D&TC meeting held quarterly.

4. The healthcare manager should review the arrangements for pathology and blood tests, including requests and results, to ensure that they are obtained in a timely manner. This should include a review of the mechanisms for patients getting results from such tests.

   Accepted – Liaise with Macmillan team to request a copy of the current pathway for patients in the community and review and amend to ensure a robust pathway for prisoners at HMP The Mount.

5. The healthcare manager at HMP Bedford should develop and agree a clear protocol for the acceptance of prisoners from other establishments, which outlines the level and limit of care available within the prison inpatient facility. The decision making process for admission should be

clinically driven and identified in the service specification for HMP Bedford and NHS Bedfordshire.

Partially accepted – The recommendation to develop guidelines for acceptance of patients with complex clinical conditions to Level 3 healthcare from other establishments is complex. Will develop a pathway to enhance the handover and discharge of patients when caretaking/assessing them for other establishments.

6. The healthcare manager at HMP Bedford should ensure that all patients have a baseline nursing assessment and a care plan initiated on admission to inpatients.

   Accepted – All patients admitted to inpatients will have a baseline nursing assessment and care plan within 24 hours of admission.

7. The healthcare manager should establish an assessment form, for completion at the sending establishment, to determine the needs and condition of patients ahead of their return from a prison with inpatient facilities.

   Accepted – Lead nurse and nurse practitioner to develop a template on SystemOne to reflect the recommendations.

8. National guidance should be agreed and developed to facilitate the assessment of social care needs of prisoners and provide care to meet the needs.

   Response to follow.

9. The healthcare manager should develop robust links with social services and ensure that social care needs assessments are undertaken when appropriate.

   Accepted – Liaise with Hertfordshire social services team based in Apsley, Hemel Hempstead and arrange a meeting to review current links and establish robust links for the future to enable social care needs assessments for prisoners as and when required.

10. The healthcare manager should ensure that care plans are in place for all prisoners with long term conditions or nursing needs.

    Accepted – Care plan processes reviewed and discussed with nursing staff during clinical supervision sessions. Care plans in place. Named nurses for specific prisoners.

11. The Governor should ensure that a new risk assessment is produced within 24 hours of a hospital escort becoming a bedwatch. This should include consideration of when and how to inform the prisoners' next of kin that he has been admitted to hospital.

Accepted – This already features on the establishment's local security strategy and is part of local escort instructions. A reminder is also mentioned on the local escort risk assessment itself. The local escort risk assessment includes a prompt to consider if and how the prisoner's next of kin should be informed that he is in hospital.

12. A full risk assessment, including an assessment of the use of restraints, should be prepared when a prisoner in outside hospital receives a significant change in circumstances. This should include a full consideration of the prisoners' diagnosis, prognosis and level of mobility.

    Accepted – Escorting officers must inform the prison whenever there is a significant change in the prisoner's medical circumstances, and the requirement to do so features in our local security strategy and local escort instructions. This will then prompt a full renewed risk assessment. Healthcare staff will also report to operations governors any such change in circumstances.

13. The Governor should ensure that all prisoners in outside hospital who are released on temporary licence have a valid and up to date licence at all times.

    Accepted

14. The Governor should ensure that staff are offered the support of the care team following a death in custody. This should include those instances where the death occurs in outside hospital.

    Accepted – Death in custody contingency plans will be amended to show that this is a requirement even where the death occurs in outside hospital.