Investigation into the circumstances surrounding the death of a man in hospital, whilst released on temporary licence from HMP Whatton, in August 2007

Report by the Prisons and Probation Ombudsman for England and Wales

June 2008

This is the report of an investigation into the death of a man at HMP Whatton. He died in August 2007 in a hospital in Nottinghamshire, with his wife and other family members at his side. He was 56 years old. I offer my sincere sympathy and condolences to the man's wife and her sons, and to all of those affected by the loss of her husband.

The man had been diagnosed with lung cancer around one month before his death, having been admitted to hospital with a chest complaint. A post mortem examination confirmed the cause of death to be carcinoma of the right lung with metastases.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by a medical practitioner on behalf of the Nottinghamshire County Primary Care Trust. As ever, I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Whatton for their full and ready co-operation during the course of the investigation. I am particularly grateful to the prison's liaison officer for the support that she provided.

I make six recommendations, including three to HMP Lincoln, and highlight one example of good practice.

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Prisons and Probation Ombudsman **June 2008**

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SUMMARY

The man was sentenced to one year's imprisonment in April 2007, and was received at HMP Lincoln on the same day. He was an epileptic, and was taking medication to control it. On his arrival at Lincoln, he also reported a history of depression and anxiety.

The man was diagnosed with a chest infection on 1 May 2007, having reported to a prison doctor that for a period of around two weeks he had been producing a frothy sputum when coughing. He had also recently reported weight loss and a loss of appetite. He was prescribed a course of amoxicillin (an antibiotic) by the doctor.

Over the course of the next week, he continued to complain of weight loss. He also said he had difficulty swallowing and, on one occasion, complained of chest pain in the early hours of the morning. As a result of these symptoms, he had an x-ray at the local hospital on 11 May. The results showed that he had chronic obstructive pulmonary disease.

On 1 June, he transferred to HMP Whatton. His medication was not given to him prior to his transfer, and it is not clear when he received a new supply. He was booked for an appointment with the prison doctor on 15 June. However, the appointment did not take place - for reasons that are not recorded.

The man subsequently saw a doctor at Whatton on 19 June, and complained of increased shortness of breath and chest pain. He was noted by the GP to have a "widespread wheeze". The doctor diagnosed a chest infection, and amoxicillin was again prescribed.

On 25 June, he again complained of "problems with his chest" and was prescribed a further course of amoxicillin. He again saw a prison doctor on 27 June, after his symptoms worsened overnight. On this occasion, he was admitted to hospital for tests.

The man did not return to Whatton. On 11 July, he was diagnosed with lung cancer and, on 17 July, released on a temporary licence for compassionate reasons. The cuffs that had been in place since his admission to hospital were removed on the same day.

The man's condition continued to deteriorate and, on 27 July, he moved to a community hospital in Nottinghamshire. He died in the beginning of August 2007, with his wife and other family members at his side.

My report shows that the man received satisfactory care at Whatton. However, the clinical review raises several concerns, including the possibility that the man's transfer from Lincoln may have led to a delay in diagnosing cancer. I make a total of six recommendations, three of which are directed at Lincoln, and highlight one example of good practice.

THE INVESTIGATION PROCESS

1. The investigation was opened on 14 August 2007 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.

2. My investigator was given access to the man's prison files, including the medical record. He visited Whatton on 5 December 2007, and interviewed two members of staff during the course of the investigation. An independent clinical review of the man's health needs whilst he was in custody was carried out by the clinical reviewer on behalf of the Nottinghamshire County Primary Care Trust.

3. My senior family liaison officer wrote to the man's wife on 23 August 2007. The senior family liaison officer and the investigator subsequently met with the man's wife on 24 October 2007. At the meeting, the widow praised the conduct of the prison officers who were on bedwatch duty when her husband was in hospital. She also raised the following issues that she wanted the investigation to address:

   - That she and her sons were very concerned and upset about the use of restraints during the man's time in hospital.

   - That it was difficult to have a private conversation with the man in the last few days of his life because, even though he had been released on a temporary licence, a prison officer was present in the room.

   - Whether his transfer to Whatton from Lincoln was appropriate, given his illness?

   - That his medication was not forwarded to Whatton when he transferred.

   - That she was not notified by the prison about his transfer to Whatton.

   - Was there a delay to the man receiving treatment following the diagnosis of cancer due to uncertainty over the best place for him to be at that time?

   - That the man may have been undernourished due to receiving supplement drinks at Lincoln but not at Whatton.

   - That she tried to claim money for petrol expenses from the Assisted Prison Visits Unit, but found the forms too time-consuming and complicated to complete.

HMP WHATTON

6. Whatton is a category C prison that currently has capacity for 821 adult male prisoners (at the time of the man's death, capacity was 761 prisoners). It first opened as a detention centre for juveniles, but its role changed in the early 1990s to that of a prison for vulnerable adult offenders. During this time, the prison developed as a specialist establishment for adult male sex offenders to enable them to participate in the Sex Offender Treatment Programme. Whatton has recently undergone a large expansion programme. All applicants for a place at Whatton must be adult males and category C sex offenders. They should not require the services of a full-time medical officer.

7. Healthcare within the prison is commissioned and provided by Nottinghamshire County Teaching Primary Care Trust. There is no 24 hour healthcare service in the prison, and no medical staff are on site during the evening or overnight. An out of hours service is provided under contract by Nottingham Emergency Medical Service (NEMS).

8. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable to hold it in their own possession. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

9. Whatton was last inspected by Her Majesty's Chief Inspector of Prisons in January 2007. She found that, whilst the healthcare unit was a clean and clinical environment, "waiting times for the GP were unacceptably long and a major concern".

10. The death of the man who is the subject of this report was the tenth death to have occurred at Whatton since April 2004, and the eighth from natural causes. There have subsequently been two further deaths of prisoners at Whatton, both from natural causes.

11. Of the previous cases that I have investigated at Whatton, two were of patients suffering from terminal cancer. Other than this, however, there are few similarities between these cases and that of this man.

KEY EVENTS

12. The man was sentenced to one years imprisonment on 13 April 2007, and arrived at HMP Lincoln on the same day. A first reception health screen (a routine health screen for all new arrivals into prison) was carried out that afternoon by a nurse. The man said that he was taking various forms of medication for depression, anxiety and epilepsy, but was unsure what they were. He said that he had last had a fit two days previously, and that he had seizures quite regularly. The nurse tried to contact his GP to confirm the medication that he was taking, but was unsuccessful.

13. On the same day, the man requested vulnerable prisoner status. He said that it was his first time in prison and he did not think he would cope on normal location. The man's request was granted, and he was allocated a place on the vulnerable prisoners' unit.

14. On 14 April, the man was seen again by the reception nurse. He said that he was a heavy smoker, and usually smoked 40 cigarettes a day. The nurse had again been unable to contact his GP. Following discussion with a prison doctor, the man was prescribed epilim 500mg (medication used to control epilepsy). On 16 April, his GP was contacted and he confirmed that the man's medication included epilim.

15. The man was seen by a prison doctor on 18 April, after he complained of weight loss and a loss of appetite. The doctor noted that he had experienced no diarrhoea or vomiting, but that he appeared to be dehydrated. He asked that blood samples be taken for tests. The doctor also prescribed him a 14 day course of co-codamol (a strong painkiller), the reason for which is not recorded in the medical record. However, when she met my investigator, his wife said that the man had slipped in the shower on 14 April and cracked a rib.

16. The results of the blood test were returned on 25 April, and were normal. On 1 May, the man was seen by a different doctor after he said that he had been producing a frothy green sputum when coughing over the last week or two. The doctor diagnosed a chest infection, and prescribed a course of amoxicillin (an antibiotic).

17. A nurse was called out to see the man at around 3.15am on 7 May 2007, after he complained of pain in the left side of his chest. The nurse took his blood pressure, which was normal, and noted that he had no pain in his arms and could move them fully. She offered him a dose of ibuprofen, which he took.

18. At around 9.30am, the man was seen in follow-up by a different nurse. She took his blood pressure and pulse, which were again normal, and noted that he had lost 800g (around 1.75lbs) in weight since 18 April. The man also told her that he had lost weight prior to coming to prison and had suffered from dysphagia (difficulty swallowing) for around two

years. The nurse thought that the man looked very gaunt and unwell. She later discussed him with a prison doctor, who suggested that he be listed to see a doctor on the following day and for a chest x-ray.

19. The man was seen by a prison doctor on 8 May. His recent chest infection, chest pain and weight loss were noted. The doctor also recorded that the man appeared to be pale, and requested a repeat of the blood tests.

20. On 11 May, the man had a chest x-ray at the local hospital. The results showed chronic obstructive pulmonary disease (COPD, a condition comprising chronic bronchitis and emphysema, the accumulation and slow release of air in the lungs). In the man's case, emphysema was the predominant feature of his COPD. There was no mention of the rib injury that he had apparently sustained on 14 April.

21. At a review by a prison doctor on 17 May, it was noted that the existence of COPD explained the man's recent chest infection. The man was noted by the doctor to be wheezy. He was given a salbutamol inhaler (medicine that helps the airways to open), to use as required, and the doctor ordered more blood tests. The results, which were returned on 23 May, showed raised inflammatory markers (a sign of redness, swelling, heat, or pain in the tissue due to injury or infection).

22. On 1 June, the man transferred to HMP Whatton. The transfer was a progressive one, moving him from a local prison to one where he could complete the offending behaviour courses necessary to proceed through his sentence. He was seen by a nurse on arrival, who noted that no medication had been supplied to him on transfer. It is not clear when he received his medication.

23. On 6 June, the man was seen by a nurse. His epilepsy and COPD were noted, and he was booked for an appointment with the prison doctor on 15 June (the first available). On 13 June, a prison GP, noted his most recent blood test results, and requested a repeat.

24. The man did not attend his appointment with the doctor on 15 June, the reason for which is not known. He did attend on 19 June, however, and was seen by the GP. The man said that he had recently been experiencing increased shortness of breath, chest pain, and had been producing coloured sputum that was tinged with blood. The doctor noted that the man was able to speak in full sentences but that he had a "widespread wheeze". Blood results, returned that day, showed an elevated white cell count consistent with infection. The man was prescribed amoxicillin, and the doctor requested that an appointment be booked for a chest x-ray. A pro forma was subsequently sent to the local hospital (although no appointment was received before he was admitted as an inpatient eight days later).

25. On 25 June, the man went to healthcare as “special sick” (a short notice appointment with a nurse). He told the nurse that he had “problems with his chest” and had been producing a frothy sputum when coughing. The man also said that he was unable to sleep at night and had a poor appetite. His weight was checked and was 45kg, an increase of 5kg since he arrived at Whatton. After discussion with a prison doctor, he was given a further course of amoxicillin.

26. The man was seen by another prison GP, on 27 June, after his symptoms worsened overnight. The GP noted that his breathing was poor and very wheezy. He gave him salbutamol through a nebuliser (a device similar to an inhaler). This had little effect. As the man was still significantly short of breath, the doctor advised that he be admitted to a local hospital for further investigations.

27. The man was accompanied to the hospital by two prison officers, and was cuffed to one of the officers by means of an escort chain (a long chain with a handcuff at both ends). Tests undertaken following his arrival at hospital indicate that he suffered a heart attack that day (27 June).

28. The man went on to have a CT scan of his chest on 4 July and, on the following day, a chest x-ray. The results of these tests, which were given to him on 11 July, showed that he had lung cancer that had spread to his bones.

29. Around an hour and a half after the man was given his diagnosis, an officer who was on escort duty at the time telephoned the prison and spoke to the duty governor. The officer asked if a risk assessment could be conducted to assess the removal of restraints “due to sores appearing on the prisoner’s wrists, his limited mobility, and considering above diagnosis”. Later that afternoon, a Principal Officer (PO) completed the “Management Daily Visit Security Risk Review” form. The PO noted that “due to the location of the ward, the removal of cuffs could be considered”.

30. On 13 July, the Consultant Respiratory Physician at the local hospital wrote to the Healthcare Manager at Whatton with further details of the man’s diagnosis. The doctor explained that the man would be having chemotherapy, as both an inpatient and an outpatient, and said that he would need oxygen therapy (the administration of oxygen at a greater concentration than in the air, to increase the supply to the lungs). He went on to say that he was unable to provide a prognosis at this time.

31. A staff nurse visited the man on 16 July to review and assess whether he was suitable to return to Whatton. The nurse completed a detailed report, in which she described how the man was extremely short of breath and only able to walk for four to five metres before becoming out of breath and requiring oxygen. She added that he was, at present, able to look after his personal care needs, but that this was likely to

change quickly as his condition deteriorated. The nurse also noted that, officially, the Consultant would not give a prognosis until palliative treatment (care that focuses on reducing the severity of disease symptoms, rather than providing a cure) had begun. Unofficially, however, it was thought that the man had only weeks to live and that his condition would deteriorate.

32. Following the nurse's assessment, the man was released on temporary licence (a temporary release from custody, in this case for compassionate reasons so that he could receive hospital treatment) on 17 July, and his cuffs were removed. A condition of the licence was that the man remained in the company of at least one prison officer at all times. His escort at the hospital remained at two officers.

33. On 18 July, the discharge co-ordinator at the hospital contacted the duty nurse at Whatton to say that they were very keen for the man to return to the prison. However, healthcare staff did not consider Whatton to be a suitable environment for him at this stage of his illness owing to the lack of 24 hour care should he require assistance overnight. They raised these concerns with the Governor, and it was agreed to investigate the possibility of him being admitted to a local hospice.

34. Following this, the staff nurse attended a multi-disciplinary team meeting at the local hospital on 24 July. It was agreed that it was not possible to manage his needs at Whatton, and that he should be transferred to a community hospital in Nottinghamshire.

35. Arrangements were subsequently made for the transfer, and the man moved to a community hospital on 27 July. He continued to be accompanied by two officers, but they were required to attend in civilian clothes rather than prison uniform.

36. The man's condition continued to deteriorate. He died at 6.30pm on 8 August, with his wife, son and grandson at his side. A post mortem report gave the cause of death as carcinoma of the right lung with metastases. The man's funeral was held on 23 August.

37. My investigator found that the prison acted appropriately in accordance with PSO 2710, the Prison Service Order that sets out the actions to be taken following a death in custody.

ISSUES

Issues raised by the clinical review

38. As noted earlier, the clinical review was conducted by a doctor on behalf of the Nottinghamshire County Primary Care Trust. The clinical reviewer concludes that the medical care that the man received at Whatton was satisfactory. However, he raises some concerns that I address below.

Prescription of co-codamol on 18 April 2007

39. The man was seen by a prison doctor at Lincoln on 18 April, apparently after complaining of weight loss and a poor appetite. He was prescribed co-codomol (a strong painkiller) by the doctor at this appointment, although the reason for this was not recorded. It is only through speaking to the man's wife that the likely reason became apparent, that the man slipped in the shower a couple of days previously and injured a rib. However, there is no mention of this event anywhere in the medical record. Indeed, only by examination of the prescription chart can it be seen that co-codamol was prescribed. The clinical reviewer notes that, "the reason for prescribing co-codamol should have been recorded in the Medical Record". I agree.

The Head of Healthcare at HMP Lincoln should remind prison GPs to record the reasons for prescribing medication in the patient's Medical Record.

The man's transfer to HMP Whatton

40. The man transferred from Lincoln to Whatton on 1 June 2007, a move designed so that he could progress through his sentence. When she met my investigator, the man's wife questioned whether his transfer to Whatton was appropriate given his illness.

41. At the time of his transfer to Whatton, the man had been diagnosed with chronic obstructive pulmonary disease around three weeks previously. He had not yet been diagnosed with cancer. The clinical reviewer notes:

> "Transfers between prisons invariably affect 'Continuity of care'. Practitioners often have a lower index of suspicion when they see a patient with a chronic disease for the first time, than when they see them for follow up when they are no better. The radiologist's chest x-ray of 11 May, the smoking history and weight loss were together strong indicators for underlying malignancy (a cancerous tumour). At this point, the man could have been placed on medical hold."

42. The clinical reviewer goes on to say that:

> "It is not unreasonable to assume that the man would have been diagnosed sooner with lung cancer if he had not been transferred. The delay in diagnosing lung cancer would only have been a couple of weeks at the most, and this would not have changed the ultimate and fatal outcome."

43. Before a prisoner transfers to Whatton, a nurse at their sending establishment is requested to complete a form to consider their suitability for a move to a prison without 24 hour healthcare facilities. A copy of the man's form was not held either in his medical record or in the archive at Whatton. It is not certain, therefore, that one was completed in his case.

44. In his clinical review, the doctor notes that, "if a transfer was necessary, better liaison between prisons would have alerted staff at Whatton that the man was unwell and required early GP review."

The Governor and Head of Healthcare at HMP Lincoln should review local systems to ensure that appropriate prisoners are transferred and those needing early GP review are identified.

45. When the man transferred to Whatton, his medication was not transferred with him. My investigator spoke to the Healthcare Manager at Lincoln, with regard to this matter. At the time, the man was written up for epilim (medication to control epilepsy) and citalopram (an antidepressant). Both were prescribed as 'not in possession', meaning that the man had to collect them each day from the healthcare centre at Lincoln. She confirmed that both of these medications were named drugs. As such, they would be ordered into stock at Lincoln specifically for the prisoner to whom they were prescribed, rather than held in stock for use as required. The Head of Healthcare said that these medicines should therefore have been given to him to take with him to Whatton. She thought that it might have been due to human error that they were not.

46. Chapter 5 of Prison Service Order (PSO) 3050 provides instructions on continuity of healthcare for prisoners when transferring between establishments. Section 5.3 instructs that, when arranging the routine planned transfer of a patient, "medication, appropriate to clinical need, is provided to ensure supply until a GP prescription can be obtained".

47. The clinical reviewer notes that, "administrative failures with prescribing when transferring between prisons are regular, and wholly avoidable, occurrences". However, he goes on to say that, "in this case, it would not have been detrimental to the man's health".

48. Nevertheless, it is worrying that a man with a history of fits was transferred between establishments without his preventative medication. I make the following recommendation:

The Head of Healthcare at HMP Lincoln should ensure that systems are in place to guarantee that medication is transferred with a prisoner when moving between establishments.

Missed GP appointment

49. At his reception health screen at Whatton, the man was identified as requiring an appointment with the prison GP. An appointment was subsequently scheduled for 15 June 2007.

50. The man did not attend the appointment. The reason for his non-appearance is not known. A clinic list is held at Whatton for GP appointments, which should give the reason for his absence. Unfortunately, the report for 15 June is missing. The man was, however, seen by a GP on 19 June, when he reported shortness of breath.

51. The clinical reviewer makes the following recommendation:

HMP Whatton healthcare needs to be satisfied that they have arrangements in place for patient review by a GP within acceptable timeframes.

Nutritional requirements

52. The man was significantly underweight when he was first received into prison. At his reception health screen of 13 April he was recorded 6' 2'' tall (although his wife later told my senior family liaison officer that the man was 5' 6''). His weight, however, was recorded as just 7st (around 44.5kg). Between his reception to Lincoln and subsequent admission to the local hospital on 27 June, his weight fluctuated between 40 and 46kg.

53. The clinical reviewer concludes:

> "The man's nutritional requirements, bearing in mind his poor appetite, were never really addressed and he only received one 200ml high calorie drink per day. However, the weight he seemed to have lost leading up to his transfer to HMP Whatton was largely regained."

Prescription of amoxicillin

54. The man was diagnosed with a chest infection on 1 May 2007, and prescribed a course of amoxicillin (an antibiotic) by a prison GP at Lincoln. On 19 June, he was prescribed a further course of amoxicillin by a doctor at Whatton, having complained of symptoms including

increased shortness of breath, chest pain and wheeziness. The clinical reviewer judges:

> "For pneumonia associated with COPD an antibiotic other than amoxicillin could have been considered, especially on the second occasion when the dose was increased during the course. However, the ultimate outcome would not have changed."

Compassionate release

55. Chapter 12 of Prison Service Order 6000 sets out the following criteria for compassionate release on medical grounds:

- 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.

56. The Head of Security and Operations at Whatton, told my investigator that compassionate release "would only ever be in exceptional circumstances from Whatton, due to the nature of the offences involved". She added that it was "considered briefly" for the man, but "given the nature of his offence and the corresponding risk assessment, was not taken further".

57. Additionally, in the man's case, it was difficult to get a prognosis that would satisfy the first condition in PSO 6000 above. On 13 July, the Consultant Respiratory Physician at the local hospital wrote to the Healthcare Manager at Whatton with details of the man's diagnosis. He said that he was unable to provide a prognosis at this time. On 16 July, the staff nurse was told that the Consultant would not provide a prognosis. There is no further evidence of any formal prognosis being provided to prison staff for the remainder of the man's life. In such circumstances, it is very unlikely that an application for compassionate release would have succeeded.

Family concerns

58. My investigator and senior family liaison officer met with the man's wife on 24 October 2007. At the meeting, she raised a number of concerns regarding the care that her husband had received during his time in custody. I have addressed some of these concerns in the section of

this report relating to the clinical review, and discuss the remainder below.

Cuffing arrangements

59. The man's wife expressed concern that her husband was chained to a prison officer during his first weeks in hospital. She said it was distressing for her and her sons to see him like this when he was ill, and also that the cuffs prevented him from sleeping at night. She said that she wrote to the Governor to request removal of the cuffs, but this did not happen for some time afterwards.

60. The man was initially taken to hospital on 27 June 2007. He was accompanied by two officers, and was cuffed to one of these by means of a closeting chain. The decision on whether or not to cuff a prisoner is made by means of an 'Escort Risk Assessment' form, with the final decision being made by someone of governor grade. The risk assessment considers factors such as the prisoner's escape risk, risk to the public, and the prisoner's conduct during their time in custody. An assessment of the prisoner's medical condition, including whether the condition restricts the prisoner's ability to escape unaided, is also considered.

61. The Escort Risk Assessment completed on 27 June, when the man was taken to hospital, noted his risk to the public as being "high", and escape potential to be "low". The escort was recommended to be two officers due to the "type of offences" that the man had committed.

62. The man was told of his diagnosis on 11 July. On the same day, the officer who was on escort duty at the time, telephoned the prison and spoke to the duty governor. The officer asked if a risk assessment could be conducted to assess the removal of restraints "due to sores appearing on the prisoner's wrists, his limited mobility, and considering above diagnosis".

63. Later that afternoon, the Principal Officer (PO) completed the "Management Daily Visit Security Risk Review" form. This is a standard form completed each day by a duty manager, usually a PO or Senior Officer (SO). The PO noted that "due to the location of the ward, the removal of cuffs could be considered". However, it is not clear if these views were passed on to the duty governor.

64. My investigator spoke to the Head of Security and Operations at Whatton. She said that, although prisoners at Whatton are category C, "if a prisoner is mobile, conscious, able to get around, they are likely to be cuffed if going from Whatton, due to the nature of their offences".

65. A protocol has been in place for security provision between Whatton and the local hospital since July 2005. The protocol says that:

> "Prisoners will normally be single cuffed and escorted by two Prison Officers, one of whom will be attached to the prisoner by restraints."

66. However, the protocol goes on to list a number of exceptions to this. Exception (iii) says:

> "Where the prisoner's condition or lack of mobility is such that he cannot escape unaided, and there is no evidence an escape attempt is likely, the escort may be manned with a singleton member of staff without restraints."

67. On 16 July, the staff nurse carried out a detailed nursing assessment. Her report included an assessment of the man's mobility, in which she noted that he was unable to walk for more than four or five metres unaided before needing oxygen. She added that he found any physical activity draining.

68. As I frequently reflect in my reports, the decision whether to cuff a prisoner at hospital is a difficult one. The balance between decency and security can be hard to find. Nevertheless, the man was a very ill man who could not move more than four or five metres unaided. I am aware of no evidence to suggest that he was an escape risk. In these circumstances, I consider that it would have been reasonable to have removed his cuffs when he was diagnosed with cancer on 11 July. Given his condition, I judge that the presence of the two prison officers would have been an adequate security arrangement.

A full risk assessment, including an assessment of the use of restraints, should be prepared by staff and considered by the Duty Governor when a prisoner in outside hospital experiences a significant change in circumstances.

Privacy in the last days of the man's life

69. The man's wife was very complimentary about the conduct of the prison officers who escorted him when he was in hospital. She described them as "brilliant", and said that they became "more like friends than officers". She specifically mentioned two officers who were brothers, and who were particularly kind to her husband. However, she said that it was difficult for her to have a private conversation with the man in the last few days of his life because of the presence of prison officers in the room.

70. My investigator discussed this with the Head of Security and Operations. She said that the instruction given to officers is that one of them should be in the room at all times. She added, "if a prisoner was likely to die, and the question was asked of the duty governor, then it is likely that they would agree to a private moment with next of kin."

71. However, it seems to me unlikely that the man's wife, or any relative of a terminally ill prisoner, would be sufficiently familiar with the workings of a prison to know that she could make such a request to the duty governor. It may be appropriate in future to offer such an opportunity to the next of kin of a terminally ill patient, subject to a suitable risk assessment.

The Governor should consider amending the Escort Risk Assessment Form to give the opportunity for the next of kin to have some private time alone with a terminally ill patient, subject to an appropriate risk assessment.

The conduct of the officers on bedwatch duty towards the man and his wife was exemplary. The Governor will wish to consider issuing a formal commendation.

The man's transfer to Whatton

72. The man's wife said that, when her husband was transferred from Lincoln to Whatton, she was not notified by Lincoln. She said that the man panicked, wanting her to be told. He had tried to call her from six different telephones in Lincoln, all of which had problems. The man was eventually able to get through shortly before lock-up to tell her that he was moving to Whatton the following day.

73. PSO 4411, section 2.4, instructs that convicted prisoners should be issued with a special letter (in addition to their usual weekly allowance) when they are about to be transferred to another establishment. However, there is no requirement for prison staff to inform a prisoner's next of kin of the transfer. Indeed, it would be presumptuous of staff to do so as there may be reasons why the prisoner does not wish their next of kin to be informed. In the man's case, I am concerned by the suggestion that so many of the phones at Lincoln may have had problems. That aside, I am satisfied that he was given sufficient opportunity to communicate the news of his transfer to his wife.

Treatment following the man's diagnosis

74. The man's wife was concerned that, due to uncertainty over the best place for him to be cared for, there was a delay in him receiving treatment following the diagnosis of cancer.

75. The man was diagnosed with cancer on 11 July 2007. On 18 July, the discharge co-ordinator at the local hospital contacted the duty nurse at Whatton to say that they were very keen for the man to return to the prison. However, prison healthcare staff did not consider Whatton to be a suitable environment for the man at this stage of his illness, owing to the lack of 24 hour care should he require assistance overnight. These concerns were raised with the Governor, and it was agreed to investigate the possibility of the man being admitted to a local hospice.

76. Following this, the staff nurse attended a multi-disciplinary team meeting at the local hospital on 24 July. It was agreed that it was not possible to manage the man's needs at Whatton, and that he should be transferred to a community hospital. Arrangements were subsequently made for the transfer, and the man moved to a community hospital on 27 July.

77. The clinical reviewer notes that:

> "Once the diagnosis of cancer was confirmed at the local hospital, it was unlikely that the man would ever have been fit to return to HMP Whatton, and an alternative facility for future care was quite rightly sought. There are often delays with finding appropriate care facilities for patients with terminal care and this case is no exception."

78. I am satisfied that staff at Whatton took appropriate steps to seek alternative accommodation for the man, once it became apparent that he was unable to return to the prison.

Assisted prison visits

79. The man's wife said that she tried to claim money for petrol expenses from the Assisted Prison Visits Unit (APVU), but found the forms too time-consuming and complicated to complete.

80. My investigator spoke to the Head of APVU. He confirmed that an application for assisted visits was received on 7 August 2007, relating to visits made on 3-4 August. The application was accompanied by a supporting letter from a senior officer, who confirmed that the man was in outside hospital.

81. The widow's application was initially rejected because she had not included proof of being in receipt of tax credit. The caseworker in APVU subsequently wrote to her on 23 August to request proof, and the appropriate documents were received on 29 August.

82. Unfortunately, she did not meet the rules to qualify for assistance. The caseworker wrote to her again on 14 September with advice on applying for a health certificate issued by the Department of Health (had this been awarded, the man's wife would normally have qualified for assistance from APVU). She did not reply.

83. Many forms requiring details of one's finances are time-consuming and complicated to complete. It is quite understandable that the man's wife found this to be the case, given the strain of travelling to visit her husband every day.

84. The Head of APVU told my investigator that the application was received on a type of form that had been taken out of use and replaced some time ago. He said that the form was not requested from APVU, and would therefore almost certainly have been obtained from Whatton. He added that the out of date form did not make a difference to the way that the widow's application was dealt with, nor the outcome.

85. Whilst I do not consider it necessary to make a formal recommendation on this matter, the Governor of Whatton will wish to ensure that his stock of APVU application forms is up to date.

86. I received the following comment after circulating my draft report:

> "the stock of APVU forms at Whatton has been reviewed. All the forms they have been able to find are up to date."

RECOMMENDATIONS

The Head of Healthcare at HMP Lincoln should remind prison GPs to record the reasons for prescribing medications in the patient's Medical Record.

Accepted – a notice has been placed in all GP rooms in the prison to remind them and a verbal instruction has been given.

The Governor and Head of Healthcare at HMP Lincoln should review local systems to ensure that appropriate prisoners are transferred and those needing early GP review are identified.

Accepted – all prisoners for transfer or release are seen and assessed by a member of healthcare the day before transfer. A verbal healthcare to healthcare handover is made when this is clinically necessary with the receiving prison healthcare. This can include ongoing healthcare needs, medication and outstanding appointments. This is documented in the prisoner's medical records. There is a local protocol for the transfer/release of prisoners.

The Head of Healthcare at HMP Lincoln should ensure that systems are in place to guarantee that medication is transferred with a prisoner when moving between establishments.

Accepted - medication is prepared ready to go with the prisoner following the pre-transfer assessment of the prisoner. A minimum of a week's supply of medication is sent with the prisoner. Pharmacy order and supply any medication required. The medication policy is currently being revised and covers the issue of medication for patients being transferred.

HMP Whatton healthcare needs to be satisfied that they have arrangements in place for patient review by a GP within acceptable timeframes.

Accepted – access to appointments has now been simplified and urgent appointments are now available within 24 hours.

A full risk assessment, including an assessment of the use of restraints, should be prepared by staff and considered by the Duty Governor when a prisoner in outside hospital experiences a significant change in circumstances.

Accepted – this matter will be taken forward by Whatton's Security Committee. The escort risk assessment form will be amended so that, in cases in which the patient is terminally ill, the duty governor should be contacted and asked for permission to remove restraints.

The Governor should consider amending the Escort Risk Assessment Form to give the opportunity for the next of kin to have some private

time alone with a terminally ill patient, subject to an appropriate risk assessment.

Partially accepted – the idea of allowing family members to have time alone with a terminally ill patient is accepted in principle. But it is difficult to use the escort risk assessment form for this purpose, especially as HMP Whatton has promised local hospitals (because of public and child protection concerns) that it will never leave prisoners on bedwatches unaccompanied by staff. Instead the work on the escort risk assessment form mentioned above will include a reference along the lines of any special requests made by the family of a terminally ill patient should be referred to the Governor. This cannot be a mechanistically determined issue. There has been a recent experience of a patient being gravely ill and then recovering enough to be returned from hospital.

GOOD PRACTICE

The conduct of the officers on bedwatch duty towards the man and his wife was exemplary. The Governor will wish to consider issuing a formal commendation.

Accepted – the Governor has written to the officers.