

**Investigation into the circumstances surrounding the
death of a man at HMP Littlehey
in September 2009**

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

February 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Littlehey. He died in September 2009 in hospital. He was 65 years old. He died nearly three weeks after being released from prison on temporary licence. His early release was arranged because of his ill health. I offer my sincere sympathy and condolences to his family and all those affected by his loss.

The man suffered from exacerbated Chronic Obstructive Pulmonary Disease (COPD), a condition where the airways to the lungs are narrowed, and metastatic malignant melanoma (skin cancer which has spread throughout the body). A post mortem examination was not carried out as the Coroner was satisfied that there were no suspicious circumstances surrounding the death. The inquest concluded he died due to natural causes.

The investigation was carried out by my colleague and assisted by a fellow investigator. An independent review of the man's medical care in custody was carried out by clinical reviewers on behalf of the local Primary Care Trust. I am most grateful to them for their assistance.

I would also like to thank the Governor and staff of Littlehey for their full and ready co-operation during the course of the investigation. I am especially obliged to the Deputy Governor and the Performance Manager for their help in liaising with my investigators.

The man had been sentenced to seven and a half years imprisonment at Crown Court in January 2005. Having initially been in custody at HMP Elmley, HMP Maidstone and HMP Bullingdon, he was transferred to Littlehey in July 2008. He had been diagnosed with COPD prior to being sentenced and the condition was managed throughout his time in custody. In June 2009 he had a malignant melanoma removed from his back but unfortunately the cancer had spread and his health subsequently deteriorated.

I make six recommendations. They centre on the initial reception healthscreen and provision of a wheelchair, the scheduling of hospital appointments by Littlehey and the potential provision of oxygen at the prison. I also consider the man's initial referral to hospital and the subsequent palliative care he received.

Notwithstanding my recommendations, this is a report of which NOMS can be proud. It is clear that staff showed a great deal of compassion when looking after the man, and I commend their use of care plans along with the consideration they gave to his location within the prison. I am also particularly pleased that he was released on temporary licence at the earliest opportunity, without any restraints but with an officer escort to provide him with some company in his final days.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man first entered custody on remand at HMP Elmley in September 2004. He was later convicted of a serious sexual offence and sentenced to seven and a half years imprisonment. He had therefore been in prison for nearly five years when he died at hospital in September 2009 at the age of 65.

The man had been diagnosed with Chronic Obstructive Pulmonary Disease (COPD) around five years before he was remanded into custody and this condition was managed throughout his time in prison. He had periods during his sentence when his symptoms deteriorated and he would receive additional medication. He transferred to HMP Maidstone in 2006, and approximately a year later was provided with a motorised trolley to assist his movement around the prison. He was also registered disabled around this time. In November 2007, he transferred to HMP Bullingdon and eight months later he was moved to Littlehey. On one occasion, he went to HMP Bedford overnight so that his extreme shortness of breath could be monitored on a 24 hour basis. He saw a doctor and was discharged back to Littlehey the following day.

Throughout the man's time at Littlehey, and following careful consideration from staff, he remained located on the induction wing, in a shared cell with another prisoner. Although there was a delay of nearly three months before he was allocated his own wheelchair, he was allowed to borrow one in the meantime from the induction wing.

In April 2009, one of the prison doctors examined the man following the discovery of a large mole on his back which had apparently changed in appearance. He was immediately referred to hospital where it was confirmed that he had skin cancer. The malignant melanoma was removed in July.

The man's condition deteriorated following this operation and he lost weight. For medical and security reasons, Littlehey staff were unable to prescribe him oxygen to assist with pain relief, but he was given other medication along with a patch that slowly released painkillers into his system. He refused to attend two hospital appointments in the month following his operation, one of which was attended by a nurse from the prison in his place. In August, he was informed that the cancer had spread to his lymph glands and the hospital would need to make further investigations to determine if it had spread any further.

A week later, the man attended a hospital appointment where he was assessed as having difficulty swallowing, along with severe back pain. The doctor recommended further investigations to determine the cause but he declined any more appointments and was therefore discharged from hospital. Back at the prison, in August, his condition rapidly deteriorated such that an ambulance was called and he was released on temporary licence to hospital. His condition continued to deteriorate and he died in the hospital in September. His funeral was held with two Governors in attendance.

In the course of this investigation I have given consideration to the prison reception process, including the delay in providing a wheelchair for the man, and I make two

recommendations in this regard. I have also considered whether the referral process to the local hospitals is robust and the scheduling of his appointments. I have made two recommendations in relation to the palliative care he received.

I am also pleased to commend the actions of staff at Littlehey in reviewing appropriate care plans for the man, demonstrating a sensitivity of judgement in relation to his location within the prison, and releasing him on temporary licence without restraints when his condition deteriorated.

THE INVESTIGATION PROCESS

1. The investigation was opened in September 2009, when the investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. Four members of staff were subsequently interviewed. No prisoners came forward.
2. The investigator was given access to the man's prison files, including the medical record. She later returned to Littlehey with another investigator in October and interviewed the four members of staff. The Independent Monitoring Board (IMB) and the Prison Officers' Association (POA) did not meet with the investigator. Littlehey has previous experiences of death in custody investigations and is familiar with all the procedures.
3. An independent clinical review of the man's health needs whilst he was in custody was carried out by two clinical reviewers on behalf of the local Primary Care Trust. One reviewer joined both investigators for the interviews at Littlehey in October.
4. My Senior Family Liaison Officer wrote to the man's former partner in October 2009 to advise her of the investigation and invite her to raise any matters she wished to be addressed. At the time of issuing this report, she had not raised any issues. I hope that this report helps his family to better understand what happened in the time leading to his death.

HMP LITTLEHEY

5. HMP Littlehey is a category C prison for convicted and sentenced adult males. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category C prisoners are defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.)
6. The prison has an operational capacity of 726 adult male offenders, but typically holds around 690. Littlehey first opened in 1988 with eight residential wings. Two additional units were added in 1997 and 2003, and in 2010 it will expand to provide capacity for up to 480 young offenders. Littlehey integrates sex offenders, who make up 80 per cent of the current population, into the normal regime of the prison. The prison offers a Sex Offender Treatment Programme as well as work and education opportunities.
7. Provision of healthcare within the prison is the responsibility of the local Primary Care Trust (PCT). A general practitioner (GP) service is provided by a local National Health Service practice six mornings a week. A nursing team works on site during the day on weekdays and Saturday mornings. At other times, advice is available through an out of hours service. There are no inpatient beds at Littlehey.
8. The prison was most recently inspected by HM Chief Inspector of Prisons on an announced visit in July 2007. In her report, she said:

“This full announced inspection confirmed that Littlehey remained an impressively safe prison, with mutually respectful staff-prisoner relationships, a reasonable amount of purposeful activity and an appropriate focus on resettlement. Littlehey remains an impressive and improving prison, able to work effectively with some very high risk prisoners. It provides a fundamentally safe and respectful environment, in which prisoners are generally occupied purposefully.”
9. Health services were described as adequate, although some waiting lists were long. The report indicated that, “Despite some good individual care, better support was also required for Littlehey’s increasing ageing and infirm population.”
10. HM Chief Inspector also thought that the resettlement strategy needed to be more comprehensive and improved assessments of risks and needs undertaken, particularly for sex offenders. However, her report noted some impressive interventions for sex offenders, with public protection being well managed.
11. In a thematic report on older prisoners in England and Wales in June 2008, HM Chief Inspector commented that Littlehey held over 182 prisoners over the age of 50, but had no long-term strategic plan for dealing with its elderly population. However, Littlehey was upheld as a good example in terms of the physical activity and bowling league provided for the over 60s. The prison had also, at the

time of the inspection, just begun to operate a specific clinic for over 65s, although its location on an upper floor meant access was difficult for the infirm.

12. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the National Offender Management Service (NOMS) and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.
13. Littlehey's latest IMB report covers the period February 2008 to January 2009. The Board considered that Littlehey "continued to be a well run prison providing a safe and respectful environment for prisoners". However, they were concerned that funding for the OAP Unit in the healthcare centre had been refused despite Littlehey's relatively high number of older prisoners, and that the post of disability/elderly officer was not full time. The IMB noted that half of those over 60 are in employment whilst the other half are unassigned and left on the wing. The gym hosts activities for this group three times a week. The IMB were disappointed that, whilst a strategy for the elderly has been discussed, it had still not been formalised: "more could be done, without spending a fortune, to meet the needs of this growing group".
14. The Board reported that "healthcare continues to operate well, despite an increase in the prison population during the period of review, and received a positive report following an audit conducted by the area team".
15. The National Offender Management Service is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Littlehey has scored a three (good performance) for the last three quarters, and before this scored a four.
16. The man's death was the 14th to have occurred at Littlehey since April 2004, when I began investigating all deaths in prison custody in England and Wales. All but two of the previous deaths were due to natural causes. My reports into these previous deaths have generally reflected well on Littlehey. Only one previous recommendation, in relation to health screening at reception, is relevant to this report.

KEY FINDINGS

17. Following his arrest and charge for a sexual offence, the man was remanded into HMP Elmley in September 2004. He was subsequently convicted at Crown Court in December. In January 2005, he was sentenced to seven and a half years imprisonment. Throughout this time he remained at HMP Elmley.
18. The man had suffered ill health and shortness of breath for around five years before his reception into custody. This was due to Chronic Obstructive Pulmonary Disease (COPD), whereby the airways to and from the lungs become narrowed. In January 2005, he had a review with the prison doctor who prescribed amoxicillin (used to treat bacterial infections) and Becloforte (an inhaler) in relation to his COPD. In August, the doctor also added salbutamol (which aids the opening of airways to the lungs) to his prescription.
19. Throughout his time in prison the man was described as being no problem to staff, attaining enhanced status in March 2005 under the Incentives and Earned Privileges (IEP) Scheme. (IEP rewards and encourages prisoners' good behaviour and has three levels – basic, standard and enhanced. Enhanced is the highest of the three.)
20. The man completed the Sex Offender Treatment Programme in June 2006 and transferred to HMP Maidstone two months later. The reception health screen (a routine health screen for new arrivals into prison) noted his diagnosis of COPD. In September, he was assessed in healthcare. He was given advice about stopping smoking and applied for the smoking cessation course.
21. Nearly a year later, in August 2007, the man had a healthcare review in which staff assessed his shortness of breath. This resulted in a motorised trolley being obtained for him to assist his mobility round the prison. He was also subsequently registered disabled.
22. In November 2007, the man moved to HMP Bullingdon. Following assessment, he continued to be prescribed the same medication and a recommendation for spirometry (used to measure the severity of lung conditions) was made. It is not clear from his medical records whether this took place.
23. The man then transferred to Littlehey in July 2008, along with another prisoner with whom he had become friends at Bullingdon. A Healthcare Officer (HCO) conducted a reception health screen. Littlehey's reception health screening form for prisoners transferring in from another establishment is different to that used in other prisons. The prisoner is asked various questions about their mental and physical health. There is no space for the interviewer to ask for, or add, any additional information, or to record any of the prisoner's concerns.
24. The man needed a nebuliser (a mist inhaled into the lungs) and staff asked for him to be assessed by the general practitioner. The doctor explained in interview that GPs are never present at a reception health screen, and will only see new prisoners when asked to do so by the reception nurse or healthcare officer. Alternatively, prisoners can make an application to see a GP themselves once

they are located in their cell on the first night. The doctor said in such instances they will usually be given an appointment for the following day.

25. During the reception health screen, the man also made enquiries about obtaining a wheelchair due to his shortness of breath but was informed this was not possible at Littlehey. During interview, the HCO explained that he believed this was Littlehey's policy since he was not aware of any other prisoners having access to a wheelchair at the establishment. The deputy governor told my investigators that this was not the case and prisoners should be assessed on an individual needs basis. However, she went on to explain that the structure of Littlehey does require prisoners to have a degree of mobility since the prison is set out over a substantial area and there are no lifts.
26. Although there was a delay in the man being allocated his own wheelchair, the deputy governor explained he would have had access to one kept for general use on the induction wing. However, this was not recorded in the medical notes. Subsequently, in September, a nurse ordered him his own wheelchair which he received in October. It was recorded in the wing history sheet that he said this wheelchair helped him greatly. There were also discussions about obtaining him a motorised trolley. The deputy governor confirmed that there would have been no objection to this in principle, but a full assessment would have had to take place as to how he would move around the prison using the trolley.
27. The man remained in a shared cell with his cellmate on the induction wing (E wing) for the duration of his time at Littlehey. Prisoners normally only stay on this wing during an initial period in the prison of up to two weeks while procedures and the regime are explained to them. They would then be moved to another residential wing. E wing therefore has a relatively transient population.
28. However, E wing was assessed to be the best place for the man given his limited mobility. It is the only wing at Littlehey where everything, such as the servery and showers, is located on the same level. The cells are also slightly bigger on this wing and staff would have been able to see him more easily should he have had any difficulties. The Clinical Nurse Manager explained in interview that the decision to retain the man and his cellmate on E wing would only have been taken after a discussion between healthcare, wing staff and the man himself to make sure everyone was in agreement. She said that staff try to make sure a balance is struck between the prisoner's wishes and the most appropriate location for them. However, I have seen no evidence that staff documented this discussion.
29. The cellmate effectively acted as the man's carer and they chose to remain in a shared cell together throughout the man's time at Littlehey. Whilst Littlehey does not have an official policy in this respect, the arrangement was agreed informally in line with both prisoners' wishes. The cellmate collected the man's meals and assisted in other ways as necessary. The deputy governor said that Littlehey has a policy of trying to place those with health difficulties in a shared cell so that one prisoner can raise the alarm if their cellmate's condition deteriorates. Both the man and his cellmate were offered the chance to change wings but chose to stay on E wing in a cell together.

30. The deputy governor acknowledged the difficulties facing Littlehey when locating older or disabled prisoners. She said that they had submitted numerous applications for a chair lift but had never been successful in receiving the funding they required. She had recently learnt of another source of funding for elderly prisoners that was currently working with HMP Norwich. She said Littlehey had been assessed as having the third largest elderly prisoner population in the country and had been encouraged to apply for funding on that basis. If successful, this would provide links with Help the Aged, and help ensure that prisoners on release have access to the services to which they are entitled.
31. The deputy governor also told my investigators that the prison had identified a member of staff to work with disabled and older prisoners full-time. She has since confirmed that this post was filled as of December 2009.
32. Although the man was unable to work because of his ill health, the deputy governor said that he would have been offered alternative activities, some of which could have been done in his cell such as assisting with organising reception paperwork. However, again I have seen no documentary evidence that he was offered such activities - nor that he would have wanted them or been able to take part.
33. In August 2008, the man went to healthcare with severe symptoms of COPD. Prednisolone (a steroid used to treat allergic reactions), amoxicillin and salbutamol were prescribed, and he was nebulised to help his breathing. Because of his extreme shortness of breath, he transferred to HMP Bedford, where there is 24 hour healthcare, overnight in September. The doctor at Bedford assessed him and deemed him fit to be transferred back to Littlehey the following day.
34. One month later, the man was described as being breathless which was diagnosed as possibly being due to the overuse of his inhaler. The doctor continued with the same medication and also started him on Seretide (used to decrease inflammation in the lungs), with a view to reviewing this in four weeks.
35. In January 2009, the man told staff he did not want to be considered for release on parole licence. The reasons were not recorded.
36. The man had an appointment in April during which he showed the doctor a large mole on his back that had become sore and was bleeding. In order to rule out malignancy (cancer), the doctor immediately referred him to the dermatology department at the local hospital. This referral took place under the National Health Service (NHS) two-week rule for suspected cancer. (The two-week rule was introduced by the NHS to ensure that patients with suspected cancer would be seen within 14 days of being referred by their general practitioner.) It is unclear whether the man was seen as a result of this referral as it was not recorded in his medical records.
37. During interview, the doctor indicated that he would have dictated the referral letter for the secretary to then type up and post or fax. He said he was not aware

of a formal follow up process for hospital referrals at Littlehey; it would be up to a prisoner or nurse to check the progress of the referral. The doctor commented he was aware of other referrals that had gone missing.

38. The man had an appointment with another doctor in May who made another urgent referral to the hospital which was faxed to them on the same day. This referral notes that the man had a mole on his back which was growing rapidly. A care plan was started at this point which was appropriately reviewed. Ten days later, a hospital doctor assessed him in the dermatology department at the hospital and referred him on to a plastic surgeon for removal of the lesion which had been diagnosed as a malignant melanoma (a skin cancer). Records indicate that this letter was typed, and presumably sent, in May.
39. In June, the man had his chest and upper abdomen x-rayed at the hospital to check his lung function in relation to his COPD. Ten days later he was seen by the plastic surgeon who apologised for the delay in him being referred to him from dermatology. (The reason for this delay remains unclear.) Four days later he was admitted for the removal of the malignant melanoma at another hospital. He underwent surgery the following day and remained an inpatient at the hospital until July when he returned to Littlehey. A referral to follow up oncology (the branch of medicine dealing with cancer) was made.
40. A nurse observed the man in July and noted he was having considerable difficulties breathing. She consulted the doctor regarding an assessment for oxygen therapy, which had been prescribed for him while at hospital. The doctor made an onward referral for this oxygen assessment for "symptomatic, wound healing and prognostic benefits" and the man was seen by another nurse who concurred oxygen would be beneficial. This nurse noted in the medical record that, for security reasons, she did not think this would be possible.
41. During their interviews with staff my investigators asked about these security implications. Whilst the deputy governor had been unaware that the man had been refused oxygen, she explained that a full risk assessment would have been required before it was prescribed. This would be to ensure that he was the only prisoner able to have access to the oxygen, and also to assess its potential to be used to assist a prisoner's escape. The flammable nature of oxygen would also have been an issue, more so since both he and his cellmate smoked. Oxygen was never prescribed for him at Littlehey.
42. A prison doctor assessed the man in July and recommended that he start on Fortisip (a nutritional drink for those who cannot maintain a balanced diet) because of his visible weight loss. Four days later, the man refused to go to his hospital appointment as he said he had been given insufficient warning to get up. The clinical nurse manager explained that details of hospital appointments are given to the staff on the wings the night before an appointment and would reach the prisoner by about 8.00pm. She said that if prisoners refuse to go to an appointment staff try to encourage them to do so. But if they continue to refuse, medical staff will rebook the appointment or re-refer the prisoner.

43. This particular appointment was rearranged at a later time. Again on this date, the man said he was unable to go to the hospital since he felt unwell. A nurse went in his place. It was planned that a doctor would visit him on the wing to discuss his results and move him to a healthcare facility closer to his home, ready for his approaching release date.
44. Later that day, the doctor saw the man and explained that the cancer had spread to his lymph glands (the lymph glands act as the 'cleaner cells' of the body and are part of the immune system), and he would need to be assessed by an oncologist at the hospital to determine if it had spread anywhere else. The doctor gave him a leaflet on melanoma to provide more information. He also formulated a care plan for him. This was to increase the meal supplements, ensure he attended oncology appointments at the hospital, and to review regularly his decision that he did not want to move nearer his former partner and did not want her to be told about his diagnosis.
45. The clinical nurse manager confirmed during interview that the man was also offered the services of Macmillan Nurses who offer information, support and advice to people diagnosed with cancer. However, she said that he was a private man, who did not like to discuss his difficulties, and he declined the offer, feeling he had all the support he needed from prison staff. (This discussion is not recorded in the medical record.) She was of the opinion that he was fully aware of his condition and was co-operative with treatment. But he also knew his own mind and made his own choices regarding his clinical care. She went on to say that Littlehey had not had much contact with Macmillan Nurses as they had not had the need to.
46. The next day, a nurse telephoned the hospital as she was concerned regarding the rapid deterioration in the man's health. She was advised to start giving him Forticreme (a nutritional supplement) to increase his strength in the hope that he could attend all his future hospital appointments. In August, the clinical nurse manager telephoned his probation officer as she was concerned that his discharge board to plan his release had taken place in July when his prognosis was more positive. She advised his probation officer that she was concerned for his welfare on release.
47. When the man was seen in August by a nurse in his cell, he was struggling to speak due to the pain. He was given pain relief, including the use of a Butrans Patch which slowly releases a painkiller into the system over a number of days. He remained adamant that he did not want his former partner to be told of his condition. He intended to live with a friend in Maidstone on his release which was scheduled to be in September 2009.
48. Healthcare staff reviewed the man's care plan to include adequate pain relief and the management of his weight loss through Fortisip, Calogen (a meal supplement), soups, and other foods that appealed to him. The plan also included management of his COPD, observation and care of his pressure sores, and to ensure his privacy and dignity at all times.

49. In August, the man had an oncology appointment at hospital. The doctor noted that he was suffering from dysphagia (difficulty swallowing) and back pain for which he was receiving morphine. The doctor recommended a Computerised Tomography (CT) scan (an x-ray procedure that takes images of the whole body and is able to give good pictures of the soft tissues which do not show on ordinary x-rays) and an endoscopy (a procedure whereby a camera is passed down the patient's throat) to investigate further. The man declined this further investigation saying he was feeling better since starting on meal supplements. No further review was planned but the hospital indicated he could be seen again as required. He was discharged.
50. The following day, the clinical nurse manager telephoned the doctor to obtain a more specific diagnosis and prognosis so that she could consider the possibility of compassionate release. The doctor was unable to be more specific since the man had refused to have any further investigations the previous day. She also spoke to the man about the possibility of moving to a prison closer to his release area. This would have facilitated social visits, as well as reducing the distance he would need to travel home once released. It would also make it easier to put together a community care package. He declined this offer, indicating he wanted to stay at Littlehey for as long as he could. He had made friends there, particularly his cellmate who provided him with much support. It was agreed that he would stay as long as possible at Littlehey and that no decisions regarding his transfer would be made without involving him.
51. The next day, when the clinical nurse manager went to visit the man on the wing, his condition had significantly deteriorated. He was having difficulty breathing and his pain was widespread. She took his blood pressure and called an ambulance to transfer him to hospital. She told my investigators that he still did not want to go to hospital but she felt there was no alternative as his condition had deteriorated so significantly. The man's cellmate was very upset. Again staff offered to contact his next of kin (his former partner), but he refused saying that they should receive their first call from the prison after he died.
52. The man was transferred to hospital as an inpatient. He was released on temporary licence (ROTL) on condition that he was escorted by one member of staff with no restraints. The deputy governor explained that a risk assessment was completed as part of this ROTL and it was felt that, in light of his mobility problems as well as his deteriorating condition, no restraints were necessary. She also explained that an officer escort as a licence condition was included on the basis of decency and support rather than for security. Prison staff were aware that the man had no visitors during his time at Littlehey, and the escorting officer was therefore mainly to provide some company for him at the hospital.
53. My investigators discussed the possibility of compassionate release with both the clinical nurse manager and the deputy governor. They both said that it was not considered for two reasons. First, his release date was imminent. Second, as he had not had any visitors during his time at Littlehey, they felt that if he was released to a hospital he would be very much on his own, with no family or support.

54. Having kept in regular touch with the hospital, the prison staff were informed that the man's condition was terminal with spinal metastases, meaning that the cancer had spread. Oxygen was administered and he was bed bound. The clinical nurse manager asked the hospital's palliative care consultant about the possible next steps given the man's imminent release. The consultant felt the man would be likely to stay on the ward until his release when he could be moved to a nursing home or hospice.
55. The clinical nurse manager visited the man the next day in order to consult him on decisions about his care. She again offered to contact his former partner or write her a letter, which he once more declined. She reflected that she felt the officer accompanying him was providing him with some company, and she asked him where he would like to spend his final weeks. He replied that he would like to be in Whitstable, Kent. During interview, she told my investigators that she felt that the prison had good links with palliative care specialists in the hospital, and that any recommendations they made were adhered to by prison staff.
56. During an evening in September, the man's condition deteriorated. The deputy governor visited and read some birthday cards to him which had been sent by members of his family. He then agreed that his next of kin could be contacted, but asked that they did not visit. The deputy governor called his former partner that evening to tell her of his condition.
57. The following morning, at 3.50am, an officer noticed that the man had stopped moving and informed the ward nurse. Twenty minutes later the doctor confirmed that he had died.
58. The deputy governor telephoned the man's former partner to break the news. She then travelled to the former partner's home, along with the prison's family liaison officer to offer their condolences and further support, including offering to pay for the cost of the funeral. His former partner said she would inform his older son.
59. The following day, the prison's family liaison officer rang the man's son as he had received a message to contact him. He explained the procedures, what would happen next, and the support available to him from the prison. The prison family liaison officer formally identified the man's body. His funeral was held and was attended by the deputy governor and governor.
60. All the staff to whom my investigators spoke said that they felt well supported by Littlehey's care team when they were told about the man's death.
61. An officer, who works on E wing, told the cellmate about the man's death. The officer said the cellmate was understandably upset. He remained with him for a substantial period of time and offered the support of all E wing staff. The cellmate made a request to attend the funeral, but since he was not a close family member, this was denied on security grounds.
62. The chaplain at Littlehey said he would have held a memorial service for the man at the request of prisoners or staff, but no one had asked him to do so.

ISSUES

Reception health screen

63. The man transferred from Bullingdon to Littlehey in July 2008. A reception health screen was carried out following his arrival at the prison. Unlike the 'first reception health screen form' which is universal throughout the Prison Service for new entrants to prison, the reception health screen form for prisoners transferred from other establishments is not standardised. PSO 3050 allows for each prison to "develop a local protocol and procedure ... to meet its local needs".

64. The reception health screen at Littlehey was conducted by the HCO, who completed the form in full. Whilst the form contains questions relating to some specific chronic diseases, including asthma, there is no space for the patient to give any additional information about their medical history or concerns they have. Although they were unable to say for certain, the clinical nurse manager and the clinical reviewer were both of the opinion that the man might have been aware that his mole was an issue when he transferred to Littlehey. It would therefore be helpful if space were available on the form to record any additional information or concerns.

65. Following a death due to cancer at Littlehey in January 2009, I recommended that

"the Head of healthcare at Littlehey should consider amending the reception health screen to allow space for additional information about significant diseases or operations not covered elsewhere on the form".

66. This recommendation was accepted and Littlehey indicated the action had been completed as of January 2010. I now further recommend that:

The Head of Healthcare at Littlehey should consider amending the reception health screen to allow space on the form for additional information about prisoners' concerns.

67. The other clinical reviewer comments that he was unable to confirm whether a full medical assessment of the man took place at reception. PSO 500 (Reception Procedures) states that the purpose of a medical assessment in reception is "to determine whether they [prisoners] have any immediate healthcare needs and whether they present a risk of harm to themselves or to others".

68. PSO 500 indicates that a full search must take place to prevent prisoners bringing unauthorised articles into custody. Full medical examinations would not take place unless deemed necessary due to concerns a patient has about their health. The man did not tell medical staff about the lesion on his back until nearly a year later. I am unable to comment on how long he had known that this might be a problem; although he did tell staff and prisoners that he knew he had been ill for some time. The clinical nurse manager confirmed that he would have had plenty of opportunity to discuss this with medical staff. As would be the case in the community, it is the responsibility of the prisoner to alert medical

professionals to their concerns.

Provision of a wheelchair

69. The man was incorrectly informed during the reception health screen that he would not be able to have a wheelchair at Littlehey. This was despite the fact that he had already been registered disabled and had use of a motorised trolley at his previous establishment. Although staff told my investigators he would have been able to borrow one from the wing, this was not recorded in the medical record. There was a delay of around three months before he was given his own wheelchair. It is apparent that having his own wheelchair made it easier for him to cope in Littlehey. I make the following recommendation:

The Head of Healthcare should ensure all staff are aware of equipment available to prisoners, including wheelchairs, and the process for obtaining such equipment.

70. The clinical reviewer comments that a prisoner's mobility requirements must be assessed before their arrival at a prison to ensure the establishment to which they are being transferred is suitable. Since Littlehey is a category C prison, transferred prisoners come from other establishments rather than directly from court. In the man's case, Bullingdon provided Littlehey with his ongoing medical record. As Littlehey does not have type three healthcare facilities, meaning there is no inpatient unit or 24 hour healthcare, the clinical nurse manager said an assessment was made before the man's transfer that he could cope at Littlehey. However, this is not documented in his paperwork. HMP Bedford is the nearest prison with type three healthcare, and the deputy governor told my investigators that prisoners will normally be transferred there if they need a higher level of care than can be provided at Littlehey.

Location of the man on the induction wing

71. The man lived in the induction wing (E wing) throughout his time at Littlehey. This allowed him to have access to everything on one floor and also to remain in a shared cell with a cellmate, who had become his friend and unofficial carer. Both the man and his cellmate seem to have benefited from this arrangement, and it seems to have provided him with some comfort as he became increasingly ill. Both prisoners were offered the chance to move wings, or in the man's case to move prisons to somewhere with type three healthcare, but they preferred to remain where they were. The man's inclusion in the decision making as to where he was located is very much apparent from his records. I make the following observation:

Allowing prisoners with limited mobility to remain on the induction wing for longer periods so that they can access facilities and share a cell is good practice.

Older and disabled prisoners

72. The deputy governor was realistic regarding the difficulties facing Littlehey with regard to their older and disabled population. I welcome the efforts she is making to secure funding to improve access around the prison, along with the recent appointment of a full-time officer to work with this group of prisoners.

Referral to dermatology

73. The man initially disclosed the lesion on his back to prison staff in April. He was subsequently referred to dermatology but this referral seems to have been misplaced. A second, urgent referral was faxed to the hospital in May when the man again presented himself to the prison doctor. Subsequently, he attended a dermatology appointment ten days later. Five days after this he was referred to a plastic surgeon in relation to having the mole removed. He had an appointment with the plastic surgeon in June, and underwent the operation to remove the melanoma. This was nearly two months after his first disclosure of the melanoma to the prison doctor.
74. During interview, the prison doctor indicated that a two week wait would be expected for an urgent initial referral. This is in line with the guidelines introduced by the NHS regarding referrals for suspected cancer. Since the man was initially referred in April and was not seen until May his appointment fell outside these guidelines. The doctor also said that, after this initial appointment, the referral to plastic surgery should only take around five days. The clinical reviewer indicates that there should be:

“... a maximum of one month from an urgent referral for suspected cancer to the beginning of treatment. If a patient waits longer it should be because of delays in the diagnostic process and not the system of care.”

The man's treatment therefore seems to fall outside the national guideline with regard to timeliness.

75. The clinical reviewer also says:

“Hospital appointments need to be chased where appropriate to ensure the prisoner is seen in a timely manner in line with national guidelines for the condition for which they are being referred ... There needs to be a mechanism in place to ensure that when appointments are not provided to time that the hospital where they have been referred are contacted and the appointment chased and this is recorded in the IMR.”

76. I make the following recommendation:

The Head of Healthcare should ensure there is a robust procedure with regard to referrals to outside hospitals and, where no appointment is obtained within national guidelines, this should be followed up and noted on the IMR. This is particularly pertinent for patients suspected of having a

malignant disease who are entitled to be seen under the NHS “Two week rule”.

The PCT may wish to take steps to ensure that local hospitals are adhering to this rule, although the matter is outside my formal remit.

Care Plans

77. Following the discovery of the malignant melanoma on the man’s back in May 2009, healthcare staff consistently used and reviewed care plans. This included a plan to increase meal supplements and to ensure he attended oncology appointments at the hospital. It also involved the regular review of his location and whether he wanted his former partner to be informed of his condition.
78. The clinical reviewer comments, “Care plans were set up at an appropriate time for the man and discussed with him. They were regularly reviewed by healthcare staff as different issues arose.”
79. During the investigation, the genuine level of care and concern demonstrated by staff was evident. It is clear from the medical notes that staff from all areas, as well as the prisoner were involved in making the man’s illness more manageable and making him comfortable. I am pleased to note the compassion shown by all those who dealt with him and consider they should be commended.

The Governor should commend staff for their care and compassion in managing the man, clearly involving him in formulating his care plans, which were appropriate and reviewed regularly.

Prescription of oxygen

80. In July 2009, the prison doctor referred the man for an assessment for the prescription of oxygen which had assisted him when he was an inpatient at hospital. This assessment indicated oxygen would be beneficial to assist with his breathing and for pain relief. However, it was subsequently decided that this prescription would not be possible due to the security risks presented and the fact that he and his cellmate smoked (oxygen is highly flammable). The clinical reviewer comments that the referral and assessment therefore seemed pointless unless the man agreed to stop smoking. He recommends that, “Healthcare should discuss with the prisoner prior to referral to ensure there will be concordance with the proposed treatment”.
81. I make the following recommendation:

The Head of Healthcare, in consultation with the security department, should consider whether prescription of oxygen would be possible at Littlehey. Any risk analysis should be completed prior to referral of a prisoner to hospital for assessment for oxygen therapy and in full discussion with the prisoner.

Attendance at appointments

82. In July and August 2009, the man refused to attend hospital appointments as he said he had not been given enough notice or could not get out of bed. The clinical nurse manager was very clear during interviews that all prisoners were informed of their appointments at 8.00pm the day before they were due to attend. This is in line with security procedures. However, it is not recorded that the man signed disclaimers, as would be expected, for the appointments he missed.

83. The clinical reviewer comments that:

“It can be difficult when a prisoner has a chronic illness that affects their ability to mobilise and they need time to get ready for an appointment. It is essential that where hospital and transport timings allow a later appointment, that this should be considered.”

84. It should be noted that the first appointment the man missed was in the morning. This was rearranged to an afternoon appointment in August, thereby trying to accommodate his needs. However, he still felt too weak to attend and a nurse was sent in his place. The appointment was again rearranged and he attended on another date in August. After the initial appointment, staff therefore made considerable efforts to enable him to attend his hospital appointments, explaining the importance of them and on one occasion sending a nurse in his place to obtain more information regarding his condition. Ensuring he could attend his hospital appointments was also subsequently included as part of his care plan. Nonetheless, I make the following recommendation:

The Head of Healthcare should ensure that, where possible, hospital appointments for prisoners with chronic illnesses are arranged at a convenient time of day, and they are given sufficient notice.

Release on temporary licence and early release on compassionate grounds

85. The man was released on temporary licence in August 2009 for compassionate reasons because of his very poor health. I am very pleased to note that no restraints were applied to him given his poor health and limited mobility. When released, he had one officer escorting him to provide company rather than for security reasons. I commend these actions:

The man was released on temporary licence around three weeks before his death with an officer escort, thereby providing him with the comfort of some company in his final days. This is a demonstration of good practice.

86. As I have noted above, early release on compassionate grounds was not considered for two reasons. The man was due for release anyway in September and, if released earlier, it was feared he would have been isolated because he had no visitors. On these grounds, it was felt that release on temporary licence was preferable. I judge that this decision was both kind and proper in the specific circumstances.

Palliative care

87. The clinical nurse manager told the investigators that the man was offered a Macmillan Nurse but that he declined the offer, although there was no evidence of this in the medical record. She also gave consideration to moving him to a prison with appropriate healthcare nearer his home, and contacted his probation officer for their thoughts on the matter.
88. After the man was admitted to hospital the palliative care consultant discussed his options with him, including going to a nursing home on his release. The consultant also advised the clinical nurse manager that the next step would possibly be a nursing home or hospice as he believed the man only had a few weeks left to live, and that he would be in hospital until his release date.
89. The next day, the clinical nurse manager visited the man in the hospital and asked where he would like to spend his final weeks. He replied he would like to go to Whitstable and she agreed to discuss this with the consultant.
90. The clinical reviewer comments that:

“Palliative care pathways in HMP Littlehey are not developed, although care planning and coordination of care needs across organisational boundaries does occur. To date Macmillan Nurses have not been utilised. When prisoners require the higher levels of care they are referred on to other centres but with an ageing prison population the earlier stages of the pathway need to be considered ... The Gold Standard framework for prisons is due to be developed next year but in the interim healthcare should consider recommendations made in the Gold Standard framework as well as input from community palliative services.”

91. The Gold Standard framework is concerned with helping people to live well until the end of their life once diagnosed with a terminal illness. It aims to ensure that patients receive the right care and treatment at the right time. I make the following recommendation:

The Head of Healthcare should consider developing protocols and links with local Macmillan Nurses and strengthening palliative care pathways. They should also consider recommendations made in the Gold Standard Framework.

CONCLUSION

92. Staff at Littlehey made considerable efforts to make the man as comfortable as possible. Whilst not an ideal prison for a wheelchair user, staff ensured he remained located in a cell with a friend, who also acted as an unofficial carer, until he was transferred to outside hospital shortly before his death. The importance of the man's own opinions in decisions regarding his own care is clearly apparent from records and interviews with staff. It is well documented that he wanted to stay at Littlehey for as long as his condition allowed.
93. Furthermore, the man's release on temporary licence with an officer escort, around two weeks before his death, afforded him dignity and some company during his final days. Although I have made recommendations regarding particular points of his care, including palliative pathways, appointments and hospital referrals, I assess that overall staff acted with compassion and in the best interests of him in accordance with his own wishes.
94. In sum, this is a report that reflects well upon Littlehey and NOMS as a whole.

RECOMMENDATIONS

1. The Head of Healthcare should consider amending the reception health screen to allow space on the form for additional information about prisoners' concerns.

This recommendation was accepted. A review of the local reception screening tool will be undertaken by the Clinical Services Manager.

2. The Head of Healthcare should ensure all staff are aware of equipment available to prisoners, including wheelchairs, and the process for obtaining such equipment.

This recommendation was accepted. A review will be undertaken of current procedures and a NTS produced to ensure clarity.

3. The Head of Healthcare should ensure there is a robust procedure with regard to referrals to outside hospitals and, where no appointment is obtained within national guidelines, this should be followed up and noted on the IMR. This is particularly pertinent for patients suspected of having a malignant disease who are entitled to be seen under the NHS "Two week rule".

This recommendation was accepted. A review will be undertaken with the AO appointments to understand current practice and ensure national targets are achieved.

4. The Head of Healthcare, in consultation with the security department, should consider whether prescription of oxygen would be possible at Littlehey. Any risk analysis should be completed prior to referral of a prisoner to hospital for assessment for oxygen therapy and in full discussion with the prisoner.

This recommendation was accepted. The Head of Healthcare will meet with the Head of Security to examine the feasibility of prisoners using oxygen in their cells.

5. The Head of Healthcare should ensure that, where possible, hospital appointments for prisoners with chronic illnesses are arranged at a convenient time of day, and they are given sufficient notice.

This recommendation was accepted. The AO appointments will review the current systems in place with the Security Department.

6. The Head of Healthcare should consider developing protocols and links with local Macmillan nurses and strengthening palliative care pathways. They should also consider recommendations made in the Gold Standard Framework.

This recommendation was accepted. The Head of Healthcare will explore developing greater links with local palliative care specialists.

GOOD PRACTICE

1. Allowing prisoners with limited mobility to remain on the induction wing for longer periods so that they can access facilities and share a cell is good practice.
2. The Governor should commend staff for their care and compassion in managing the man, clearly involving him in formulating his care plans, which were appropriate and reviewed regularly.
3. The man was released on temporary licence around three weeks before his death with an officer escort, thereby providing him with the comfort of some company in his final days. This is a demonstration of good practice.