Investigation into the death of a man whilst in the custody of HMP Wakefield in July 2011

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report into the death of a man at HMP Wakefield in July 2011. The man died of natural causes. A post mortem concluded that he died from metastatic bronchogenic carcinoma (lung cancer). I offer my condolences to his friends and family.

One of my Family Liaison Officers contacted the man's wife about the investigation to provide the family with the opportunity to raise any issues about the care which he received whilst he was in custody.

The investigation was carried out on my behalf by my colleague. I would like to thank the Governor and her staff for their co-operation.

I am also grateful to Wakefield District NHS Primary Care Trust (PCT) for appointing the clinical reviewer to review the man's clinical care. As the man died from natural causes, the findings in the clinical review are essential to my own conclusions. The review concludes that the standard of care which he received was equitable to that which he could have expected in the community. The clinical reviewer's clinical review is the only annex to the report.

Like many Wakefield prisoners, the man had lived there for some years. He had a number of medical conditions which were well monitored and he received a good level of health care whilst at Wakefield. I make no recommendations for improvement and highlight communication between Wakefield and Pinderfields Hospital as an area of good practice.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen
Prisons and Probation Ombudsman **February 2012**

CONTENTS

SUMMARY

1. The man was remanded into custody at HMP Manchester in June 2007 for and was sentenced to 10 years imprisonment. He was transferred to HMP Wakefield in May 2009. The man had a history of asthma, was prescribed a number of medications and disclosed that he was a heavy smoker. He was subsequently diagnosed in October 2009 with chronic obstructive pulmonary disorder. (COPD is used to describe a number of conditions including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.)

2. In June 2010, the man was diagnosed with lung cancer, and was placed under the care of a consultant oncologist (cancer specialist) at Pinderfields General Hospital, Wakefield. Healthcare staff maintained close liaison with Pinderfields, and despite the man refusing to attend some appointments or take his prescribed medication, he was encouraged by staff and family to comply.

3. The man was unable to undergo chemotherapy or radiotherapy treatment as his cancer had progressed too far and in June 2011 he was referred for palliative care (the form of healthcare that focusses on relieving and preventing the suffering of patients). He was moved to a specialist palliative care cell the in-patient unit Wakefield, as he did not meet the criteria for release on compassionate grounds. The man died in July, with his family present.

4. The clinical reviewer concluded:

   > "Overall the man received an excellent standard of care whilst at HMP Wakefield. His care was more than equitable to that which he could have expected in the community".

5. No issues have been identified and, accordingly, no recommendations are made as a result of this investigation. The level of communication between healthcare staff at Wakefield and specialists at Pinderfields Hospital is noted as an example of good practice.

THE INVESTIGATION PROCESS

6. The investigation was opened on 28 July, when one of the Ombudsman's investigator, contacted the Head of Litigation who was to act as the liaison officer for the investigation. Notices were issued announcing the investigation to staff and prisoners. Wakefield confirmed these were displayed around the prison. The Ombudsman's investigator was provided with all documentation relating to the man. No staff or prisoners came forward in response to these notices. The case was transferred to my colleague as lead investigator on 30 August 2011.

7. Wakefield District NHS Primary Care Trust (PCT) asked the clinical reviewer to review the man's clinical care on their behalf. He was provided with the man's medical records to assist this review. We thank the clinical reviewer for undertaking this review and for his timely report.

8. The Ombudsman's investigator contacted Her Majesty's Coroner for West Yorkshire Eastern District to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

9. An Ombudsman's family liaison officer contacted the man's wife on 23 August, to inform her about the investigation and to invite the family to ask questions or raise concerns about the care of the man whilst he was at Wakefield. The family had the following questions:

- Why were restraints used during hospital visits for scans, despite hospital staff requesting that they were removed?

- Why were visits poorly managed by Wakefield? When the man had become very frail and poorly, visits were still held in the visits hall. Following a complaint from his family, visits were moved to healthcare, but during one visit (which was in a room downstairs from healthcare) the man was brought in a wheelchair and they felt he should have been allowed to stay in his bed.

- Why was communicating with the appropriate people at Wakefield so difficult? In the week prior to the man's death this had improved, but generally it was very difficult and they felt that their calls were often 'passed from pillar to post'.

- Why was the man not moved to the healthcare centre sooner?

- Can Wakefield confirm that the PPO notices were displayed around the prison? (addressed in paragraph 6).

10. The investigation assesses the following aspects of his care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether the man was told about his condition and the treatment which followed?
- Whether he was treated properly and attended hospital appointments as necessary?
- Whether the liaison with his family was appropriate?
- Whether he was accommodated in the most appropriate part of the prison?
- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

The man's family received a copy of the draft report as part of the consultation process. Having considered the investigation findings they provided some further written comments. The investigator has reflected these in the report at paragraph 38.

HMP WAKEFIELD

11. HMP Wakefield is a high security prison of which there are only eight in England and Wales. It is located between the city centre and a residential district, housing in excess of 750 prisoners of category A, B, and high security remand. There are four residential wings, A, B, C, and D, of which B wing houses remand prisoners in a separate unit. Prisoners are also located in the healthcare centre, the segregation unit and closed supervision centre both located on F Wing. Outside agency services are provided by a number of agencies, such as healthcare from the local PCT.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State for Justice if they have any concerns. They also submit annual reports about how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

    In their annual report for the period 1 May 2009 to April 2010, the IMB made the following comments:

> ”The ageing population of Wakefield does raise our concerns regarding available accommodation and purposeful activity not just for the ageing but for the prisoners of limited abilities. Simple activities we feel should be more available for the prisoners of limited ability.”

    In respect to the provision of the healthcare centre:

> ”The Primary Care Centre has now been in operation for a full year and is providing a comprehensive first-contact service throughout the time that cells are unlocked. Medication is dispensed three times each day with up to 100 prescriptions being filled at each morning session. Seasonal immunisations are administered when appropriate. A GP is available from 8 o’clock in the morning until 6 p, with an average of 30 prisoners on call-up each day for the treatment of acute conditions. The Unit also provides a number of regular clinics for the management of chronic illnesses and the detoxification of drug misusers.
>
> ”The in-patient unit contains 15 beds and is normally working to full capacity with a mixture of elderly, infirm, chronic illnesses, and psychiatric cases … overall the Health Care Unit provides a comprehensive service that meets the needs of the prison population.”

HM Inspectorate of Prisons

13. HM Chief Inspector of Prisons last conducted a full announced inspection of the prison in December 2008. The then Chief Inspector noted that since the last full inspection in 2003:

> "Wakefield has improved considerably over the last five years and it is pleasing that in general the improvement has been sustained. There is still work to be done on aspects of safety, staff-prisoner relationships and activities, but the principal issue to be tackled is how to motivate and engage serious sexual offenders, so that their risk is reduced and they can progress through the prison system."

Person Escort Record (PER)

14. This is a form that accompanies prisoners on all journeys from and between prisons, police and court. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, e.g. meals served, times journey started etc.

Restraints

15. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs, double cuffs or two metre long escort (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary

Categorisation

16. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. The man was a category B prisoner, for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Prison Service Order (PSO) 0900, gives guidance on appropriate assessment.

Previous deaths in custody at Wakefield

17. There have been seven previous deaths at Wakefield in the past year. My colleague reviewed the Ombudsman's reports into these deaths and she found no issues in common between the earlier deaths and that of the man's.

ISSUES

The diagnosis of the man's terminal illness

18. The man entered custody in June 2007, and had a history of asthma, hardening of the arteries and narcolepsy (a long-term sleep disorder that disrupts a normal sleeping pattern). He had disclosed that he was a heavy smoker, with no wish to stop. He was transferred to Wakefield in May 2009. In October, having complained of experiencing shortness of breath, he was diagnosed with COPD and referred to the 'Stop Smoking' group, but he did not attend.

19. In May 2010, the man was experiencing generalised pain and told healthcare staff that he was unable to put on weight; his weight was recorded as 50kg. He was referred for a chest x-ray which he had on 8 June, and on 14 June prison doctor A reviewed the x-ray report that stated lung cancer was suspected. The man was referred to a specialist, a consultant in General and Respiratory Medicine at Pinderfields, who also runs a weekly clinic at Wakefield, under the two week rule (when cancer is suspected a patient should be seen by a specialist within 14 days). The consultant examined the man three days later, on 17 June. During this consultation, which took place at Wakefield, the man was told that he had suspected lung cancer and he needed to have an urgent CT scan (a computerised tomography (CT) scan is a special type of x-ray using a scanner and computer equipment to take pictures of the body). This scan was arranged for 2 July, however, despite being told how urgent this examination was, the man refused to attend this appointment. He signed a disclaimer that he did not want to accept treatment.

20. On 29 July, the consultant told the man that he needed to have an urgent bronchoscopy (a procedure which can help to diagnose some conditions of the airways and lungs) and a CT scan. He wrote in the electronic medical record that "the early diagnosis the better for prognosis". The man remained adamant that he did not want to go to hospital, and felt that the restraints used would be degrading. Over the next few weeks, the man was encouraged to undergo tests by staff, appointments were rearranged on several occasions with Pinderfields, but he refused to attend. However, on 27 August, following a lengthy discussion with the healthcare manager, the man eventually changed his mind and agreed to go to hospital for further tests.

21. On 17 September, the man had a bronchoscopy, which was normal. He again refused to have a CT scan on 22 September, although after some persuasion did attend for this diagnostic procedure on 11 October.

22. The man attended a consultation with the consultant on 21 October, accompanied by a nurse and was advised that his cancer had possibly spread and he needed to have a PET scan (positive emission tomography - PET scan is used to produce a detailed, three-dimensional picture of the inside of the body and used to diagnose a range of cancers and work out the best ways of treating them).

23. The man declined to go to hospital on 23 November, but did have the PET scan on 3 December. Following this scan the man's case was discussed at a multi disciplinary team (MDT – where all those involved in decision making regarding treatment attend) meeting on 6 December, where it was agreed that he should have a mediastinoscopy (a keyhole surgical procedure used to look at an area of the body called the mediastinum, which is part of the chest) to help determine the correct treatment plan.

24. On 9 December, the consultant advised the man of the outcome of the MDT meeting, and he agreed to attend for the procedure. The man was referred to a consultant thoracic surgeon (a medical doctor who performs operations on the heart, lungs, oesophagus and other organs in the chest), that same day. He was examined by him at St James' University Hospital, Leeds on 22 December. He underwent the mediastinoscopy on 16 February 2011. It determined that he was not suitable for surgery, as his cancer had spread. However, he was still considered suitable for chemotherapy plus radiotherapy (the use of high energy rays to destroy cancerous cells).

25. The man refused to see the consultant in general and respiratory medicine at Pinderfields on 24 February, so the consultant went to see him on the wing, along with the nurse, to ensure that he had the diagnosis and treatment option fully explained to him. Initially, despite encouragement by healthcare staff, the man again refused to attend hospital appointments whilst subject to restraints. However in April, following encouragement from the consultant, he agreed to see a specialist and he was referred to an oncologist (oncology is the non-surgical management of cancer) at Pinderfields.

26. The man was encouraged to keep hospital appointments by healthcare staff and his wife. On 23 May, the man's case was reviewed by the consultant in general and respiratory medicine at Pinderfields, recorded in a letter to Wakefield that the man's life expectancy with treatment was likely to be approximately 15 months, but that 'life expectancy can vary considerably among different people'.

27. On 24 June, the consultant recorded the man's life expectancy as 'very poor and in my opinion between 3 and 6 months'. The prison doctor A, spoke with the man on 27 June about his prognosis, which the man had difficulty accepting.

In his consideration of the diagnosis, the clinical reviewer concludes:

> "The man was referred promptly by prison medical staff to a consultant in respiratory medicine and was seen only three days after a chest x ray report indicated a lung problem. This initial referral was within the two week rule and all consultations were clearly and comprehensively recorded in the prison medical record. The consultant runs a weekly clinic at the prison which aided communication and continuity of care."

In light of the clinical reviewer's comments, I conclude that the diagnosis of the man's terminal illness was appropriately handled.

Informing the man about his condition and treatment

28. According to his medical records, hospital and healthcare staff ensured that the man was fully informed at all times about his condition, from the initial diagnosis and potential treatment options. Nevertheless, Nurse A recorded in the electronic medical record on 30 October 2010 that 'he [the man] does seem to be in a state of some denial'.

    In his report, the clinical reviewer comments as follows:

    > "There is clear evidence from the file that the man was given full information at each stage of his illness for the reasons for investigations and consultant referrals. When there were explanations to the man regarding treatment options the consultant was accompanied by a prison nurse which is an excellent way of ensuring communication can be reinforced. When the terminal diagnosis was reached he was told in a timely and sympathetic manner. At each stage throughout his illness psychological support was provided and an assessment of his mental state was undertaken."

29. Despite his denial of his condition, we are satisfied that he was appropriately made aware of his condition and prognosis.

The man's medical appointments and treatment

Appointments

30. The man was first suspected of having lung cancer in June 2010. He initially refused to attend for further diagnostic tests and examination by a specialist, although on occasions he was subsequently persuaded to attend. On each occasion that he refused to attend, he signed a refusal of treatment disclaimer. In total, he refused to attend outside hospital appointments on nine occasions (25.06.10, 02.07.10, 23.07.10, 20.08.10, 23.08.10, 22.09.10, 23.11.10, 22.03.11 & 10.05.11). Two other appointments were cancelled. On 16 February 2011, the hospital cancelled as the consultant was not available. On 26 April, there is an entry in the prison medical record stating that an appointment had been cancelled due to security issues. The prison advised the investigator that this information was entered in error and provided a copy of a letter showing that the hospital cancelled this appointment on 19 April, and it was subsequently rescheduled to 10 May.

    The clinical reviewer notes:

    > "The man was extremely reluctant to attend hospital appointments but medical and nursing staff were supportive and continually stressed the need for him to participate in treatment."

Treatment

31. In December 2010, at an MDT meeting, the doctors treating the man, discussed the possible treatment options and agreed that it was appropriate for him to undergo a mediastinoscopy, which was undertaken in February 2011. Following this procedure, he was referred to a specialist oncologist, to ascertain if chemotherapy and radiotherapy would be appropriate. During a Gold Standards Framework meeting (a systematic evidence based approach to optimising the care for patients nearing the end of life) on 30 June, it was agreed that as the man's cancer had spread quickly, he was not suitable for such treatment and he was referred to the palliative care team. The man and his wife were informed of the decision.

The clinical reviewer writes:

> "Appointments at outside health services were made promptly and continually rearranged despite his reluctance to participate. On return to prison following appointments and treatments, appropriate monitoring was undertaken and well documented. Communication between outside providers and prison healthcare staff was regular, consistent and well documented. The man was referred promptly to a consultant but unfortunately was reluctant to attend for further investigations which meant that he was too ill for chemotherapy and radiotherapy by the time he fully engaged with the oncologist. When his condition became terminal, his care was well planned and delivered. Overall, the man received an excellent standard of care whilst at HMP Wakefield. His care was more than equitable to that which he could have expected in the community."

We agree with the clinical review that the man's treatment was appropriate to his needs.

The man's pain relief and medication

32. The man was prescribed all the medications directed by the hospital consultant, although he often refused to take his pain relief. At the time of his death, he was prescribed the following medication:

- Paracetamol (for pain relief)
- Diamorphine hydrochloride (for pain relief)
- Midazolam (a sedative)
- Cyclizine (for nausea)
- Fentanyl (for severe pain relief)

33. When considering the man's pain relief and medication, the clinical reviewer said:

> "The man was provided with an effective pain relief programme. He had a thorough assessment and regular reviews of his medication. He was prescribed Fentanyl patches. Fentanyl is a very potent narcotic analgesic and ensured the man's pain was largely controlled. He was also given morphine and oxycodone as required for breakthrough pain. He was nursed on an airflow mattress and turned at regular intervals as his condition deteriorated. Nursing staff spent time with him, talking to occupy his mind when his family were not present."

In light of the clinical reviewer's comments, we find that the management of his medication and pain relief was appropriate to meet the needs of his condition.

Liaison with the man's family

Contact with healthcare professionals

34. In February 2011, following the diagnosis, and given the man's reluctance to attend hospital appointments, the consultant in general and respiratory medicine at Pinderfields requested that the man's wife be allowed to attend an outpatient appointment with him at Pinderfields. Unfortunately, the man declined to attend the planned appointment, but the consultant (with permission from the man) made telephone contact with his wife to ensure she was fully aware of his condition and treatment options. Whilst visiting the man at Wakefield, the consultant met with the man on a number of occasions. The consultant remained in telephone contact with his family to ensure they were aware of the man's situation.

35. The involvement of family in such discussions is by no means routine in prison and it was an example of good practice by the prison and healthcare staff, in particular the consultant as was the communication with colleagues at Pinderfields.

Visits

36. The man had regularly been visited by his wife and sister throughout his time in custody. The man's wife wrote to Wakefield on 29 June, outlining her concerns that her visits with the man were not in a segregated area of the visits hall. She was particularly concerned that he was unable to manage the journey due to his deteriorating health. (The man had access to a wheelchair but was still required to walk a short distance in the visits room.) This letter was received by Wakefield on 6 July, and sent to the Deputy Head of Healthcare, requesting a response by 19 July. There were two letters containing the same information sent to the man's wife in reply. The first response is dated 11 July, from the Deputy Head of Healthcare and the second dated 12 July, by the governing Governor. In both of these letters it states that the man's wife's letter was received on 8 July, that visits would now be held in the healthcare centre, and that the prison family liaison officer would arrange extra visits. This information was reiterated to the man's wife

during a meeting with the consultant in general and respiratory medicine at Pinderfields on 13 July.

37. In addition to the letter submitted by the man's wife, two solicitor's letters dated 6 July were received by Wakefield on 9 July, detailing the same concerns. The solicitor also enquired about the possibility of compassionate release and outlined the man's wife's frustration at not being able to discuss matters with somebody directly when she had tried to contact the prison by telephone. There were two letters containing the same information sent to the solicitors in reply by Wakefield. The first response is dated 11 July, from the Deputy Head of Healthcare and the second dated 12 July, by the governing Governor. In these letters the arrangements for visits to take place in the healthcare centre were confirmed. The letters explained that compassionate release was not an option in the man's situation (compassionate release is considered later in the report).

    The investigator put the man's family's questions about visits and communication to the Head of Litigation at Wakefield. In his response to their questions, he wrote:

> "Our intention was to keep the man's regime as normal as possible, which was in keeping with his wishes. Once we noticed deterioration in his condition and after discussion with him, it was arranged to have his visits in his room on the [healthcare centre]. The [healthcare centre] had some vulnerable and particularly disruptive offenders at this time and the aim was to ensure visits were not disturbed by other activities in the unit. With due regard to Security concerns it is not considered appropriate for Healthcare staff to discuss a prisoner's condition etc over the phone. Throughout this time, the man had daily access to a phone to contact friends and family and remained largely lucid throughout. As his condition deteriorated extended visits were facilitated and a Family Liaison Officer was appointed. It should also be noted that records indicate that Doctors had contact with the man's wife on 24/02/11, 30/06/11 and 13/07/11 (in person)"

38. On 22 July, the man's wife and sister were granted all day visits, during the core working day (Monday – Thursday between 10am to 6.30pm and Friday – Sunday between 10am to 4.30pm) and the prison authorised that they were provided with any meals and refreshments they required.

    Following the consultation period the man's family reflected that, whilst they understood the difficulties associated with the man being in prison, the family felt that the provision of easier visits should have been accommodated sooner.

39. There is clear guidance for the timeliness of replies to correspondence received by prisons. The Governor of Wakefield did respond within the timescale and, although this may have still felt a long time for the man's family, we find no grounds to criticise the establishment and judge that the response was within reasonable time.

The man's location

40. The man told staff at Wakefield that wanted to remain living on his wing for as long as possible. The Head of Litigation commented 'the decision was made in consultation with him [the man] ; he stated he was happy on the wing as this was his 'home' and wanted to stay on the wing as long as was possible with his many friends.'

41. On 24 June, staff on his wing spoke with the man as they had observed a deterioration in his presentation (he was in dirty clothes which was unlike him) and he was offered the assistance of a peer carer to help him clean his cell, amongst other tasks. The man declined this offer of help. Later the same day, the, Disability Officer, also visited him and noticed that his health had declined. The man told her he was in pain and she arranged for him to be admitted to the healthcare unit at Wakefield.

42. On 30 June, the man was moved to a palliative care cell. The Disability Officer visited him on 10 July when the man told her that he was more comfortable in healthcare and was pleased that he had been visited by some of his friends from D wing.

43. Due to The man being ineligible for early release, and that no suitable hospice bed was found prior to his death, he was appropriately located in Wakefield's in-patient unit.

Compassionate release

44. Prisoners suffering from a terminal illness and for whom death is thought likely to be imminent (generally a life expectancy of three months or less) can be considered for release from prison early on compassionate grounds. An application must be sent to the Public Protection Unit (PPU) in the National Offender Management Service (NOMS) headquarters. The application form includes sections to be completed by the Governor, a prison doctor and an offender manager (OM – who is responsible for assessing risk, managing the sentence plan objectives and authorising any release accommodation). A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Casework Section (PPCS) determine whether the application meets the criteria set out in Prison Service Order (PSO) 6000 (the instruction that deals with the release and recall of prisoners). In making this decision, they consult with the Parole Board and specialist medical advisors in the Department of Health. PSO 6000 states:

> "The criteria applied in medical and tragic family circumstances cases are as follows:
> <u>Medical</u>
>
> i. the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; <u>and</u>

ii. the risk of re-offending is past; and
iii. there are adequate arrangements for the prisoner's care and treatment outside prison; and
iv. early release will bring some significant benefit to the prisoner or his/her family."

45. The man applied for early release on compassionate grounds (ERCG) on 1 July. The Head of Litigation, requested information from the relevant departments within Wakefield, including a formal written prognosis, from the doctor and an assessment of the risk posed by the man and details of his proposed accommodation on release from offender management. The Head of Litigation also contacted the PPU to seek advice about the man's eligibility for consideration. He was advised that as the man was still considered a risk (he continued to deny his offences, had not undertaken any offending behaviour work and was still assessed by his probation officer as a risk to the public, specifically children) he was not eligible for ERCG.

46. Similar issues would have precluded the man being considered suitable for an unescorted ROTL (Release on Temporary Licence). However, he could have been considered for release under escorted ROTL, if his consultant had felt that the man's condition could have been better managed in a care home/hospice. No such arrangements were proposed by the consultant and we judge that, in the circumstances, it was reasonable not to do so as the man was being treated in a palliative care cell.

Palliative care plans

47. Palliative care is defined by the National Institute for Clinical Excellence (NICE) and the National Council for Palliative Care (NCPC) as:

> "the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments."

48. The man was placed on the Gold Standard Palliative Care Framework. This is a means of optimising the care for patients nearing the end of life, and is aimed specifically at medical staff. The man's care was reviewed at monthly meetings of the Gold Standard team (including the consultant in general and respiratory medicine at Pinderfields and visiting nurses), the details of which are recorded in the electronic medical notes. An end of life care pathway was established, which is a robust guide that includes all aspects of care that might be required for someone who is terminally ill. One of the important features of the plan is monitoring someone's pain, and there is evidence that at almost every encounter healthcare staff had with the man, they asked if he needed any additional pain relief.

49. On 1 July, at a Specialist Palliative Care Team meeting, the Macmillan nurse (a specialist cancer nurse) met with the man during a visit to Pinderfields. The Macmillan nurses continued to have input into the man's care plan and were willing to visit him at Wakefield when required.

50. In addition to his physical care, visits from his friends were facilitated by nursing staff and arrangements were made for his wife and sister to spend time with him during the last days of his life.

51. Prison healthcare staff provided intensive input after the man was admitted to the prison healthcare unit. He received a high standard of care with attention to both his physical and emotional needs. Staff should be commended for their input

Restraints, security and bed watch

52. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment is undertaken to consider the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs, double cuffs or two metre long escort (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

53. Wakefield considered the risk posed by the man to the public, his security category (B) and assessed that double cuff restraints were to be used and that he would be escorted by two officers (double cuffs refer to two sets of handcuffs being used: one set applied to the prisoner's wrists and one cuff of the second set is attached to the prisoner and one to an escorting officer). On each occasion, the man attended outside hospital or was admitted to hospital, this assessment was reviewed. Authority was given to remove restraints if requested to do so by medical staff for examination and the use of an escort chain was authorised during admissions.

54. Later in the investigation, my colleague wrote to the Head of Litigation for further information relating to the decision to using restraints during hospital visits, as the man's family had raised this as an issue. In response, the Head of Litigation stated:

> "A risk assessment was completed in advance of each attendance at hospital where all relevant factors were considered; including medical opinion. It was noted that medics recommended allowance be made for the man's use of a walking stick, and accordingly it was agreed that he would be discharged from the prison on a single cuff as opposed to being double cuffed. Once a prisoner is discharged, the Risk Assessment remains dynamic and cuffing arrangements can be further altered with a Governor's authority in response to treatment requirements etc: such decisions once again take account of all factors,

including medical opinion but are not defined by this alone. It is noted from the records that on the 14/06/11 cuffs were removed to facilitate treatment. There is no record of any other occasions were hospital staff requested the removal of cuffs. For clarification, the circumstances where restraints would be removed entirely are extremely rare e.g. prisoner is under a general anaesthetic. All decisions on restraints are taken with full regard for the welfare of the prisoner, but are overarched by our duty to protect the public.

55. The man did not want to attend hospital appointments whilst subject to restraints. He told staff he found it degrading and exercised this right on a number of occasions. The man's wife raised concerns that restraints were used during hospital visits and it is hoped that this report provides an explanation for the decisions made. Permission was authorised for the removal of restraints when requested by medical staff for the purpose of examining the man or when he underwent any diagnostic procedure. The risk assessment procedures were appropriately followed and appear reasonable in the circumstances.

CONCLUSION

56. During his time at Wakefield, the man had well documented and regular interactions with doctors and other healthcare staff. There was good liaison between healthcare staff and hospital specialists to ensure that the man received appropriate treatment and medication, and this was at least equivalent to that available in the community. Evidence shows that the care given to him by prison healthcare staff was of a high standard. His family were able to spend time with him during his final days and were with him when he died. The clinical reviewer concludes:

> "Overall, the man received an excellent standard of care whilst at HMP Wakefield. His care was more than equitable to that which he could have expected in the community."

57. We agree with the clinical reviewer's conclusions. While it is appreciated that his family had concerns about his care, it is to be hoped that they are reassured by the findings of this investigation.