Investigation into the circumstances surrounding the death of a man at HMP Whatton in October 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the circumstances of the death of a man at HMP Whatton, on 4 October 2008. No post mortem was undertaken but he had been diagnosed with bowel cancer. He was 68 years old.

I would like to offer my sincere condolences to the man's family and all those who knew him and were affected by his death. Despite the very difficult circumstances, I hope that the family found comfort in being with the man in his final hours.

My colleague conducted the investigation on my behalf. One of my Family Liaison Officers spoke with the family. They told her they were happy with the support they had received from the prison, particularly that offered by a Senior Officer.

An independent review of the man's medical care was undertaken by a clinical reviewer on behalf of the local Primary Care Trust (PCT). Not for the first time, I am grateful to the clinical reviewer for his contribution.

I would also like to thank the Governor of Whatton and her staff for their cooperation. I am particularly grateful to the Head of the Secretariat and the prison liaison officer who provided a very high standard of prison liaison and ensured the prison documentation was in exceptional order. The Vice Chair of the Independent Monitoring Board also made a very valuable contribution to my investigation.

I make three recommendations in my report. The first relates to the need for a formal process for selecting and paying prisoners who conduct carer duties. The second asks the Head of Healthcare to ensure that discipline officers assigned to healthcare adhere to the strict boundaries of their role and do not assume clinical roles. The third recommendation is addressed to the Governor and is designed to ensure that all prisoners who are terminally ill are given the opportunity to apply for compassionate release if they wish.

My recommendations aside, I judge that the care the man received at Whatton was of a high standard. I was particularly pleased that the prison made the difficult decision to allow the man to die at Whatton. The prison does not have 24 hour healthcare facilities and special arrangements as to healthcare provision and accommodation had to be made.

I am pleased to commend the SO who demonstrated exceptional commitment to his role as the prison's Family Liaison Officer. There have been 16 deaths at Whatton since my office began investigating all deaths in prison custody in 2004. My

commendation for good practice in family liaison on this occasion is consistent with what I have discovered in those previous investigations. This reflects very well both on Whatton and on the Prison Service as a whole.

The prison service has accepted my recommendations and their response is documented on page 21 of my report.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

In March 2005, the man was remanded into custody at HMP Pentonville, charged with a violent sexual offence. He later received a nine year prison sentence with a three year extended licence. The man was an elderly man when he was convicted and, although this was not his first experience of prison, he had not had contact with the criminal justice system for over 20 years. He was noted to be nervous at first, but settled well and staff at Pentonville found him polite and good at his work as a cleaner.

In his first interview with healthcare staff the man said he had suffered bowel problems in the community, and that his doctor had recently referred him to hospital for further investigation. The bowel problems continued while the man was in prison and in June 2005 he underwent further investigations. The tests did not show anything untoward and a further test was advised. However, the man refused to undergo the test and the opportunity to establish the possible cause of his symptoms was lost. In early 2006, he was transferred to HMP Whatton.

The man attended healthcare over the next couple of years for a variety of ailments including athlete's foot and a shoulder problem. According to his healthcare records, he received appropriate treatment for these conditions. During this time, he was diagnosed with a cancerous tumour on his eye but refused to be treated. (There is no doubt that the man had the mental capacity for making that decision.)

In June 2008, he attended healthcare complaining of significant weight loss, pain in his abdomen, loss of appetite, bloating in his stomach and bowel problems. In July, the man was referred to the Queen's Medical Centre in Nottingham for investigation under the National Health Service two week deadline rule for suspected cancer. He received an appointment within the deadline and a scan was arranged for 11 September. The man's health continued to decline and the results given to healthcare on 19 September revealed that he had primary bowel cancer with secondary tumours in his lungs and liver.

The man was told of the situation by the prison doctor and chemotherapy was discussed but not advised due to his frailty. He told the prison doctor that he had no wish to be resuscitated and wanted to die at the prison. Arrangements were made to respect his wishes, although this was a difficult decision as a similar situation had not occurred previously. Some wing staff were uncomfortable with the idea and, in the absence of 24 hour healthcare facilities, felt that the man should have been moved to a hospice or hospital for end of life care. However, the prison doctor - who has considerable experience in palliative care as a doctor in the community - was confident that it could be managed successfully. The man was moved to A8 wing which had a bigger room, greater privacy and easier access for his family and healthcare staff.

Healthcare staff visited daily and detailed arrangements were made for healthcare cover at weekends and at night. Appropriate arrangements for palliative care were made in order to manage the man's medical and emotional needs in his final days. The needs

of his next of kin were also addressed within this framework. Instructions were given to staff regarding the security arrangements for the syringe driver which contained pain relief and anti-sickness medication. A list for weekend cover contact numbers was available to wing staff.

The Senior Officer (SO) arranged for the man's family to make what was to be a final visit to him. The SO was aware that not all the wing officers were comfortable with the prison's decision to allow the man to die at the prison. He came into the prison on his rest day to facilitate the family visit and make sure that all went well. My investigator learned that arrangements were underway to facilitate a room in healthcare for any future visits.

The man died on 4 October 2008 with his family at his bedside. My investigation found that he had received a high standard of care during his illness and its final stages, allowing him to die with dignity and according to his wishes.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 4 October 2008. Terms of reference and notices were issued to staff and prisoners at Whatton telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, clinical record, and other records relevant to his time in custody and his death.

2. My investigator also contacted HM Coroner to inform him of the nature and scope of my investigation. She was informed that a post mortem had not taken place. The inquest was held on 4 March 2009 and the verdict was death by natural causes. The Coroner will be sent a copy of my report.

3. My investigator visited Whatton on 9 January 2009. She met the Governor, the Senior Officer (SO), who acted as the prison's Family Liaison Officer, the prison doctor and with prisoners. My investigator toured the prison and visited C wing where the man was located prior to his transfer to A8 wing. She spoke with prisoners and staff who knew the man and also with the nurse who had been assigned the task of caring for him while he was located on C wing. My investigator visited A8 wing and saw room A8-13 where the man spent the final hours of his life in the company of his family.

4. A clinical review of the man's medical care was commissioned from the local Primary Care Trust and undertaken by the clinical reviewer. The clinical reviewer focussed on the medical and end of life care the man received at Whatton. His review appears as an annex to this report.

5. One of my Family Liaison Officers spoke with the man's family. They had no concerns they wished to raise other than reassurance that Blackmore had received the appropriate medical care and treatment in prison.

HMP WHATTON

6. HMP Whatton is a category C training prison for prisoners convicted of a sexual offence or offences, or who have a sexual element in their offending history.

7. In response to overcrowding across the prison estate, Whatton underwent rapid expansion in 2006, increasing the operational capacity from around 400 prisoners to 841 by 2008. Up to this point, the main focus of the prison was in accepting prisoners who had been assessed as suitable for sex offender treatment programmes because they were not in denial of their offence. (These courses are designed to the lower risk of re-offending.) In response to the rapid expansion and to fill the new places, the admission criteria were changed. The prison then began to accept offenders who were in denial of their offence and who had been assessed as unsuitable for undertaking specialist offending behaviour courses.

8. Healthcare at Whatton is provided by the local Primary Care Trust (PCT). The Independent Monitoring Board report for the period June 2007 to May 2008 praises the healthcare department for delivering a "high level of healthcare to one of the most demanding and diverse sections of society". (It should be noted that the average age of prisoners at Whatton is far higher than elsewhere in the Prison Service.) The prison does not have 24 hour healthcare facilities and medical staff are not on site during the night or at weekends (I have commented on this in previous death in custody reports). Out of hours medical care is provided by Nottingham Emergency Medical Services (NEMS).

14. My investigator spoke with the Vice Chair of the Independent Monitoring Board, who expressed a number of concerns. These included that fact that sex offenders may share rooms and be vulnerable to bullies (it was acknowledged that, owing to population pressures, Whatton was unable to provide single rooms). The Vice Chair also said the IMB were pleased with the palliative care offered by the healthcare department.

15. In her inspection report dated March 2007, the HM Chief Inspector of Prisons said many aspects of the regime at Whatton that had been applauded in a previous inspection were still in place. She acknowledged that the prison had to fully adapt to the changes it had been asked to take on so rapidly.

17. There have been 16 deaths at Whatton since my office began investigating all deaths in prison custody in 2004.

KEY FINDINGS

18. On 18 March 2005, the man was remanded to HMP Pentonville having been charged with a violent sexual offence. On the same day, he underwent a first reception health screen interview with a member of the healthcare staff. It was noted on the health screen document that the man said he had seen a doctor a few months before his remand because of stomach pains and had been referred to the Middlesex Hospital. The document also shows that he suffered from asthma and an appropriate referral was made to see the prison doctor. The man gave the member of staff who conducted the screening the impression that he was "very nervous and apprehensive" about being in prison.

19. The man's medical record shows that he was seen by a doctor the following day. He told the doctor that he had attended hospital on an emergency basis a few days before his remand. Acute constipation was diagnosed and he was prescribed medication. The man told the doctor that he was not getting this medication in the prison. The doctor explained that this was because he had not offered that information to staff at the first health screen interview.

20. Wing records show that, despite his apprehension and nervousness at his initial healthcare interview, the man settled in well. He was employed as a cleaner and complied with the prison regime. He had enhanced status under the Incentives and Earned Privileges (IEP) scheme, and an entry in his wing record dated 9 September 2006, described him as polite and helpful. (The IEP scheme is used as an incentive to encourage and reward good behaviour in prisons. There are three levels - basic, standard and enhanced. Incentives include access to in-room television, more private cash to spend, wearing own clothes, and more time out of cell.) The man was moved from his cell on the ground floor of A wing to the second floor to allow a prisoner who needed ground floor accommodation to be located there. However, he found climbing the stairs to the second floor difficult because of his asthma and so wanted to be relocated to the first floor when a cell became available.

21. Abdominal discomfort appears to have continued throughout the man's early months in prison, resolving only around May 2005. My investigator noted an entry in the medical record which said that on 12 May the man attended healthcare complaining of weight loss, nausea, and stomach pain with a loose stool and some red blood. The entry said an examination was not carried out because an exam couch was not available on the wing.

22. A doctor at Pentonville referred the man to the Whittington Hospital. In a reply dated 8 June 2005, the Colorectal Nurse Specialist confirmed that investigations found nothing untoward at this point. A further investigation was planned and arrangements were made for the man to have a flexible sigmoidoscopy and be seen in the hospital clinic afterwards. (A sigmoidoscopy is a procedure whereby an instrument is inserted into the rectum to detect colitis or cancer of the rectum.)

23. An entry in the medical record on 12 October says that a “flexible SD” booked for 22 June had been cancelled as the man refused to attend hospital and had signed an “instruction against medical advice on the same day”. No reason for the man’s refusal appears to have been noted. The significance and impact of the man missing this opportunity to undergo further exploratory tests for his abdominal problems will remain unknown.

24. The man attended healthcare in Pentonville and subsequently in Whatton on a regular basis throughout his sentence. He was treated for a variety of ailments including asthma, athlete’s foot, and shoulder pain for which he received paracetamol and ibruprofen and, latterly, diclofenac and steroids.

25. Of more concern to healthcare staff was the “very large bcc” (basal cell carcinoma) on the man’s right eyelid that he told staff he had had for around 40 years. (A basal cell carcinoma is the commonest form of skin cancer and is usually found on the face.) He underwent a biopsy and on 17 January 2006 the Senior House Officer, Department of Dermatology, referred the man to the Consultant Plastic Surgeon.

26. On 7 April 2006, the man transferred to the newly expanded HMP Whatton. It appears that, on his transfer, healthcare staff at Whatton made a referral to a Queen’s Medical Centre, Nottingham, regarding the man’s eye problem.

27. Initially, the man settled in well at Whatton. However, in November 2006 he told his personal officer that he was experiencing difficulties in contacting his younger son. He was advised to pursue the matter through the court system. The man’s frustrations came to a head on 8 February 2007 when he was told by probation that he had to wait until his son contacted him first through the Family Centre. The man did not handle the situation well and was disrespectful to staff. His enhanced status on the IEP scheme was reduced to standard and he no longer spoke openly with his personal officers.

28. A letter dated 30 January 2008, from the consultant dermatologist, to the healthcare department reported that the man had failed to attend two previous eye appointments and no further appointment was to be made at that stage.

29. The man was asked to attend further appointments with healthcare staff on 18 February and 20 March 2008 to discuss why he did not wish to attend hospital for his eye appointments. On 18 February, the man explained that he did not refuse to go, but that the handcuffs were too tight and he was unable to wear them. The medical record entry for 20 March says that the man ”is fully aware of the implications and states he did not want the appointment reinstated”. He signed a disclaimer and the hospital was informed.

30. The medical record shows that the man went to healthcare in May 2008 and said that his shoulder pain was better. His next appointment was on 2 June when he was found to have a urinary infection. Medication and advice on diet was given by a

Nurse. Bowel problems continued throughout June. On 21 July, the Nurse referred the man to the doctor after he told her that he was not eating, had lost weight and was still suffering from abdominal pain.

31. Following a medical review on 24 July, the man underwent a series of tests. The clinical reviewer notes that the man still refused treatment for the basal cell carcinoma on his eye. He reports that the blood tests showed a marginally raised white cell count and a "raised CRP[c-reactive protein] of 77mg." (CRP indicates inflammation or infection.) As the man's abdominal pain had not improved, an urgent referral was made on 28 July to the colorectal clinic under the two week rule as "underlying bowel malignancy" was suspected. (The two week rule is implemented when cancer is suspected and a patient is referred to a hospital specialist and seen within two weeks of the referral.)

32. The man was assessed by the consultant colorectal Surgeon, on 11 August. The following day, the consultant colorectal surgeon wrote to advise healthcare that further investigation was necessary.

33. While awaiting appointments for further investigation, healthcare continued to treat the man's falling weight with fortified drinks to supplement his meals, as well as ibruprofen and paracetamol for his stomach pain. An entry in his clinical record dated 10 September says that the doctor was to visit the man in his room because he felt too unwell to get out of bed and he "appears to have deteriorated over the last couple of days". A fellow prisoner and disability co-ordinator, recalls that the man did not like the nutritional drinks healthcare gave him to supplement his diet. (A disability co-ordinator at Whatton is a prisoner who acts as a link between the prison and disabled prisoners. He helps by giving practical and emotional support to disabled prisoners.) In interview, the prisoner said that the man did not take as much of the drinks as he should, and consequently became dehydrated. He remarked that the prison palliative care nurse, was "tremendous with him" and visited him every day.

34. A prison doctor reviewed the man on 10 September, noting that he was dehydrated and due to go for a scan the following day. The plan was that, if the man could not drink the necessary fluids that afternoon, he was to be admitted to hospital and the scan could be done while he was there. The man did manage to drink the correct amount of fluids and so had the scan the following day as arranged.

35. The clinical reviewer notes that on 19 September the prison had to telephone the consultant colorectal surgeon's secretary for the results of the scan. Although the report was available, the consultant was on leave and it had not been verified. Healthcare staff were told that the man's cancer had spread to his lung, liver and ascending colon, and this indicated a tumour in his bowel. The clinical reviewer is concerned that the prison had to ask the hospital for results. My investigator asked the prison doctor, whether this was common practice and she confirmed that it was a problem. However, she emphasised that, in her experience, it was also a problem

within general practice in the community. She said that the palliative care nurse has been allocated the task of enquiring after test results from hospitals, but admitted that communication with the hospital was not as good as it could be. She also explained to my investigator that she had telephoned because the man's health deteriorated further and she suspected an underlying condition.

36. The clinical record shows that, realising the seriousness of the man's illness, the prison palliative care nurse telephoned the district nursing team at East Bridgeford practice to request the loan of a syringe driver and other equipment necessary for the man's comfort. (The syringe driver is a method by which a painkiller such as morphine is pumped continuously through a needle inserted in the skin.) A locked cupboard in the man's room to store his controlled drugs was also a necessary safeguard. Arrangements were put in place for him to be moved to A8 wing and the necessary equipment was awaited.

37. Changes to the man's every day medication were made to control his symptoms. Although by now very frail, the man continued to attend to his own personal care.

38. Following confirmation of his diagnosis from the hospital, the prison doctor had a lengthy discussion with the consultant oncologist about the benefits and disadvantages of chemotherapy. The prison doctor said she then discussed the results of the scan with the man and asked for his opinion. He told her that he thought he had cancer. The prison doctor explained that his condition was inoperable and they discussed the advantages and disadvantages of chemotherapy. The man made the decision that he did "not wish to do anything which would prolong his life". He said he had spoken with the chaplain and the chaplaincy would inform his family. The prison doctor recorded the man's instruction that he did not wish to be resuscitated in the event of a collapse. She also completed the necessary documentation to alert the out of hours healthcare staff.

39. A prisoner and the disability co-ordinator said that the man found himself in a real dilemma in telling his family about his illness. This was because the man was not himself told of his illness until it was terminal and then it "could be quite quick". In speaking with my investigator, the prisoner was clear that the man had made up his mind that he wanted to die at Whatton among people he knew. He added that the man "did not die an angry man".

40. Following his move to room A8-13 on 24 September, healthcare staff continued to visit the man daily. His medication was adjusted as necessary to help with sickness and pain control. Healthcare staff provided personal care in his final days, but were unable to set up the syringe driver as the locked cabinet required to hold the medication had not arrived. The syringe driver had become necessary as the man struggled to keep medication down because of his sickness.

41. My investigator visited A8-13. She noted that the room was large and located at the very end of the wing so that some privacy was possible. She was told that the door

was left open and a heavy curtain could be drawn across it. The curtain had a net viewing panel across the middle to allow staff to monitor visitors to the room, giving privacy from the wing while leaving the door open. My investigator considered this to be sensitive to the prisoner and his visitors, whilst appropriately maintaining the security of the prison.

42. The prison doctor told my investigator that she felt confident in managing the man's physical and emotional needs. She said that she had developed a degree of expertise in palliative care over the years and was able to anticipate any problems that might arise. She thought that, as prison staff were on hand and healthcare staff visited several times a day, the man was not alone. She said that the process for making sure that drugs were available, and that there was safe storage and access to them out of hours, was essentially the same as in the community. She said she considered whether to admit the man to hospital but did not believe it necessary. Terminally ill patients in the community were usually admitted because carers could not cope. She confirmed that some senior prison healthcare staff were trained to use syringe drivers. The prison doctor explained that, because this was the first time the prison had cared for a terminally ill prisoner who wished to die in the prison, both she and the palliative care nurse set up the syringe driver so they were happy with it.

43. During the man's illness, officers asked another prisoner if he would assist in providing care for the man. The second prisoner explained to my investigator that he was a wing carer in the prison. He said that he was paid £3.00 per week extra for the work. (He was about to receive lifting and handling training on the day my investigator visited Whatton.) In preparation for his role, the second prisoner said he was vetted by security and given strict boundaries about the care he could give. He told my investigator that he was not allowed to give personal care such as washing and dressing. Although he was trusted to get a key to the locked medicine cabinet in the room, only the patient was allowed to remove medicines from the cabinet. He said he brought the man his meals. He added that the highest number of prisoners he has had to care for at one time is three.

44. The prisoner disability co-ordinator was attending a wheelchair handling course on the day my investigator visited. He explained that he brought the man's meals to him and made sure he had fresh water all the time. He also helped him dress but did not undertake any personal care. He told my investigator that he "kept on at staff to get him to healthcare for a shower but nothing was done". However, the prison's Family Liaison Officer told my investigator that the man was an independent man who wanted to undertake his own personal care and that he managed this until the day before he died.

45. The second prisoner said his room was located two doors down and on the other side of the corridor from the man. The second prisoner claimed the man had been "ill for about five weeks before healthcare took any notice".

46. The man's wing history sheet records that on 29 September 2008 his daughter-in-law spoke with prison staff about visiting. He told staff he was reluctant for family other than his brother to visit. His brother and other members of the family visited on 4 October and were with the man when he died.

47. On 30 September, the man's personal officer on A8 wing introduced himself and noted that the man was "in very good spirits … and still manages to share a joke with me". The personal officer added that the man "is very happy with the level of care he is receiving and although he is clearly in some pain, he says he is comfortable". The personal officer confirmed the man's next of kin details with him. The man's family wrote to ask him to let them visit.

48. The prison Family Liaison Officer arranged a visit for the family on Saturday 4 October.

49. The prison Family Liaison Officer came into the prison on his rest day especially to facilitate the visit with the family and to make sure it went as well as possible. The man was the first terminally ill prisoner to stay at the prison and the prison Family Liaison Officer was aware that some staff disapproved, believing that terminally ill prisoners should be in a hospital or hospice and not allowed to die on the wing. The prison Family Liaison Officer told my investigator that he wanted to relieve the staff of the burden of the visit. He said that he also wanted to meet the family as "putting a face to a voice" would be so much easier for them after the man's death.

50. On 3 October, the Liverpool Care Pathway documentation was started. (The Liverpool Care Pathway was developed to ensure high quality multi-disciplinary end of life care for patients. It is designed to ensure that every aspect of patient care is attended to and that next of kin are included.) Before the family arrived, the prison palliative care nurse confirmed with the man that he did not want to be transferred to secondary care such as a hospice or hospital.

51. The Liverpool Care Pathway documented the use of the syringe driver, charting the usage in detail. A four hourly observation chart was completed to monitor other symptoms and how much morphine the man required. A prescription record sheet was completed appropriately.

52. At 3.15pm on 4 October 2008, in the presence of his family, the man passed away. Medical records show that his family were given support and advice by the prison palliative care nurse and the Duty Governor. They were also advised to contact the healthcare team in the future if they wished to ask any questions.

53. On her visit, my investigator spoke with the Governor. She told my investigator that she arrived on the wing that evening and told the other prisoners of the man's death. In interview, the prison Family Liaison Officer confirmed that all prisoners on an open Assessment, Care in Custody and Teamwork (ACCT) document were reviewed and

spoken to by staff and the Chaplain. (ACCT is a process to monitor and support prisoners at risk of self-harm and suicide

54. The Governor said that, in line with protocol, the police were informed of the man's death by the duty governor. The Governor said that in order to respect their workload, he did not make it an emergency call. She told my investigator that, nevertheless, she expected the police to arrive at a reasonable time. However, they did not arrive until very late at night. The Governor said that a prisoner who knew that the man had died and that his body had not been removed committed an act of self-harm. She felt the two events were related.

55. The prison Family Liaison Officer told my investigator that the staff welfare team were available to support staff. He also reported that the prison had held a memorial service for the man. The prison Family Liaison Officer said that he did not invite the family as they were distraught immediately after the man's death and, with the very best of intentions, he did not consider it appropriate for them to be present. My Family Liaison Officer spoke with the family after the man's death. They told her they would have welcomed an invitation to the memorial service as it would have been an opportunity to meet those who cared for the man. The prison Family Liaison Officer has confirmed that he will invite families in the future.

ISSUES

The clinical review

56. The clinical review was undertaken by a clinical reviewer for the local Primary Care Trust (PCT). His review is based on prison medical records and liaison with my investigator. As noted earlier, in his interview, a fellow prisoner and carer claimed that the man had been "ill for about five weeks before healthcare took any notice". However, the clinical reviewer concludes that the care the man received was entirely appropriate. In the clinical reviewer's opinion, the man died with dignity, in the presence of his family and that all his healthcare needs in his final days were met. Notwithstanding the fellow prisoner's evidence, I agree with the clinical reviewer's assessment.

Managing terminally ill prisoners

57. Opinion appears to be divided as to whether terminally ill prisoners should be managed on the wings at Whatton. The average age of prisoners at Whatton is much higher than at other establishments and from time to time it is inevitable that someone will become terminally ill. The man was the first prisoner who chose to die in the prison. The prison Family Liaison Officer told my investigator that some staff were clearly not comfortable with this, a factor of which the Governor is aware and also mentioned to my investigator.

58. Whatton does not have 24 hour healthcare cover so the prison doctor drew up a rota of staff who could be contacted out of hours in case an emergency should arise. Healthcare staff regularly visited the man during the day and early evening to ensure he was comfortable and that his symptoms were managed. The clinical reviewer concludes that the man received good care. However, the prison is in a rural location, roughly equal in distance from Nottingham and Grantham, and it is 16 miles to Queen's Medical Centre, Nottingham. There is no inpatient facility and no medical staff on site during the night or at weekends. In a previous report, I raised concern over the distance from the prison to the hospital and that it took 30 minutes for the ambulance to arrive. On that occasion, staff had to contact the Nottingham Emergency Medical Service and then called an ambulance on their advice.

59. While the family are happy with the care the man received at Whatton, they might have opted for him to have been cared for in a hospice or hospital if there had been a choice. In future cases, families may well take this view. In all the circumstances, if Whatton is to allow terminally ill prisoners to die at the prison, 24 hour healthcare is the most appropriate method of managing their care safely. Alternatively, arrangements for the transfer of terminally ill prisoners to an establishment with an inpatient facility should be considered.

60. The Governor told my investigator how difficult it had been for the prison to decide whether to allow the man to die in the prison rather than a hospice or hospital. She

was aware that not all staff were comfortable with this, especially some staff on A8 wing where the man died. Nevertheless, my investigator gained the impression that the man's death was well managed by healthcare, and that prison staff dealt with the situation appropriately and sensitively.

Room A8-13

61. Staff told my investigator that prisoners had already stigmatised room A8-13 as being a "death room" where a prisoner went to die. When my investigator visited, she was told that another terminally ill prisoner was due to be moved there that afternoon. Staff also added that the allocation of the number '13' was unfortunate and not helpful. My investigator was told that there were plans to convert a room in healthcare both for general purposes and also so that terminally ill prisoners who wish to die in the prison can be cared for with privacy by the healthcare team. While this is preferable to A8-13 on the wing, a room in healthcare might prove to be an isolating experience for a terminally ill prisoner.

The role of carers

62. The Vice Chair of the IMB raised the question of whether carers such as fellow prisoners should be used. The Vice Chair says that the population of Whatton is co-operative by nature, so prisoners will undertake the task if asked. He has observed that prisoners at Whatton are very supportive of terminally ill prisoners but not all are paid. He said that caring was not structured and was based upon officers approaching a prisoner's friend and asking if they would take on the role. The role of carer is not monitored (I note that the fellow prisoner and disability co-ordinator assisted the man with dressing while the second prisoner - his paid carer - did not). This supports the Vice Chair's finding that some prisoners were carrying out duties as carers for which they were paid and others were not.

    The Governor should ensure that carer duties are only carried out by those prisoners who have gone through a formal selection process and that such prisoners are paid.

Healthcare appointments

63. When she visited the prison, my investigator noted the long distance between C wing and the healthcare department. In talking with my investigator, the prisoner and disability co-ordinator expressed some empathy for the dilemma confronting healthcare in deciding at what point healthcare staff should visit the prisoner. He said that he had wheeled the man "over to healthcare and waited ages" on a number of occasions. A concern both he, the second prisoner, and the Vice Chair of the IMB, raised separately was that an informal and inconsistent priority system was operated by some discipline officers in healthcare. Both prisoners and the Vice Chair gave my investigator the impression that the length of wait in healthcare for prisoners to be seen by nursing staff was directly linked to the level of empathy the

officer possessed. This also suggested a level of diagnosis from officers who prioritised prisoners to be seen by healthcare.

The Head of Healthcare should ensure that the discipline officers assigned to healthcare are aware of and adhere to the strict boundaries of their role as officers and do not assume any role or responsibilities for clinical matters.

Police response to the man's death

64. The Governor commented on how long it took the police to arrive to carry out their investigation. She said that the prison did not call 999 as it was not an emergency and they were mindful of police resources. However, she expected the police to arrive within a reasonable amount of time as the man could not be moved from the room until they had visited. In fact, the police did not get there until very late at night. The Governor felt this had caused a vulnerable prisoner, already on an open ACCT document, to self-harm. The actions of the police are outside my terms of reference. However, I suggest that the Governor may wish to bring this to the attention of the local police with a view to drawing up a memorandum of understanding regarding an acceptable timescale for the police to attend following the death of a prisoner.

Early Release on Compassionate Grounds

65. Due to the nature of their offences, it is often difficult to grant applications for release on compassionate grounds to prisoners at Whatton. However, it is by no means certain that all applications will be refused. The possibility of release on compassionate grounds should therefore be discussed with prisoners and they should be given the opportunity to apply for such release if they wish. My investigator gained the impression from the prison doctor that healthcare staff were focussed on the medical care and not on the prospects of early release on compassionate grounds. Nevertheless, discipline staff should be aware of the process and procedure.

The Governor should ensure that all prisoners who are terminally ill have the opportunity to apply for release on compassionate licence if they wish.

Commendation

66. The prison Family Liaison Officer went into the prison on a rest day specifically to ensure that the man's final visit with his family went well. He did this because he understood some officers on A8 wing were not comfortable with the prison allowing the man to die in the prison. Facilitating the man's final visit with his family on his rest day was an act over and above that expected of him and demonstrated sensitivity and understanding to both family and the staff of A8 wing.

67. The family were very complimentary about the prison Family Liaison Officer when they spoke to my Family Liaison Officer, describing him as “brilliant”. They appreciated that he attended the man’s funeral on behalf of the prison and said that they could not fault the care and sensitivity they have been shown by prison staff.

    I recommend that the Governor writes to the prison’s Family Liaison Officer to commend him for his commitment to his role as Family Liaison Officer.

Conclusion

68. The man’s death at Whatton was expected. Having initially refused hospital investigations early in his sentence, his condition deteriorated and he was diagnosed with bowel cancer which spread to other areas of his body. Owing to his frailty, chemotherapy was not considered appropriate. However, the prison took the difficult decision to care for him on one of the wings in spite of staff reservations and the fact that there was no precedent. The man’s wish to die at Whatton was respected and he died with dignity, in the presence of his family.

69. My recommendations aside, I judge that the care the man received was comparable to, and possibly exceeded, that which he would have received in the community.

RECOMMENDATIONS AND COMMENDATION

1. The Governor should ensure that carer duties are only carried out by those prisoners who have gone through a formal selection process and that such prisoners are paid.

   NOMS and Offender Health are running a pilot which aims to train prisoners to NVQ level as carers. The learning from the pilot will inform further policy, in particular the development of a prisoner profile suitable for the role. On completion of the pilot, consideration will be given to how the role can be recognised and appropriately rewarded in the prison regime. A response relating specifically to HMP Whatton will follow at a later stage.

2. The Head of Healthcare should ensure that the discipline officers assigned to healthcare are aware of and adhere to the strict boundaries of their role as officers and do not assume any role or responsibilities for clinical matters.

   Having a uniformed presence in healthcare is essential for prison order and control, particularly regarding accounting for prisoners. The officers concerned do not assume any role or responsibilities for clinical matters. PCT medical staff conduct triage on all prisoners reporting to healthcare and respond accordingly.

3. The Governor should ensure that all prisoners who are terminally ill have the opportunity to apply for release on compassionate licence if they wish.

   All prisoners have the opportunity to apply for release on a compassionate licence.

Commendation

The Governor should write to the prison Family Liaison Officer commending him for his commitment to his role as family liaison officer.

The prison Family Liaison Officer was commended by the governor on 20/5/2009.