Investigation into the circumstances surrounding the death of a prisoner from HMP Wakefield, at Pinderfields Hospital in September 2007

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the death of a man who died in September 2007 in hospital while in the custody of HMP Wakefield. He was 61 years old. I extend my sincere condolences to the man's partner, family and friends.

A post mortem was held at the request of HM Coroner for West Yorkshire (Eastern District). The man's death was from natural causes resulting from metastatic malignant melanoma, an extremely aggressive form of cancer.

The man had been admitted to hospital on 11 September 2007 after a short period of being unwell. He had been diagnosed with skin cancer in 2004 and had had surgery in August of that year. He then attended regular outpatient appointments. Sadly, his cancer recurred and he died soon after it was diagnosed.

The investigation was undertaken by one of my investigators. I would like to thank the then Governor of Wakefield and his staff for their help and assistance. I am especially grateful to two senior managers.

A review of the man's medical care at Wakefield was commissioned from Wakefield and District Primary Care Trust. I acknowledge the contributions from a senior nurse advisor and the Director of Patient Expereince/ Chief Nurse Mid Yorkshire Hospital NHS Trust. A panel of clinicians carried out the review and their report was then further reviewed by a General Practitioner. I am most grateful to all the clinicians for their assistance. However, However, the clinical review into the man's death was not received in my office until late April 2008 and this has resulted in the delay in my issuing this report, for which I must apologise.

I make three recommendations for the attention of Wakefield and District Primary Care Trust, and one recommendation for the Governor at Wakefield in relation to visiting arrangements for relations of terminally ill prisoners. I also comment on two areas of good practice.

In this final report I acknowledge the PCT's request to delete a paragraph from the investigation process in relation for the Independent Monitoring Board's report. The PCT have responded to the recommendations and action has already been taken to address those issues highlighted.

The man's partner and sister have also responded to the draft report. Their responses have been added into the report under Family Issues

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man was remanded to HMP Leeds in August 2004. This was his first time in prison. In September 2004, he was sentenced to seven years and nine months imprisonment for serious offences. After his conviction, he remained in Leeds for five weeks and then transferred to HMP Wakefield on 8 October.

Shortly before the man's conviction, he had been diagnosed with a malignant melanoma on his back for which he underwent surgery in August 2004. (This is an extremely malignant form of cancer spread by lesions or via the lymphatics or blood stream which can invade any organ of the body, especially the lungs, liver, brain, skin and bones.) During his time in both Leeds and Wakefield, the man attended outpatient clinics with a dermatologist and plastic surgeon. In November 2004, he had further surgery on his back, and thereafter there was no sign of any residual melanoma. The man was prescribed medication for high blood pressure, high cholesterol and heart related disease. He continued to have regular outpatient appointments for the next few years.

On 3 July 2007, the man was seen at the first contact clinic with a swollen left leg, knee and ankle. On 10 July, the prison doctor prescribed medication and advised him to rest his leg on two pillows. Three weeks later, the man visited healthcare complaining of chest pain, shortness of breath and sweating. His observations were taken and an electrocardiogram (ECG) was performed to trace his heart functions. The man was then taken to the local Accident and Emergency Department at a hospital and discharged later that day.

On 6 August, the man attended healthcare again as he was having dental problems with some numbness on the side of his face. Painkillers were prescribed, he was advised to see the doctor if the symptoms persisted, and an urgent appointment was made for him to see the dentist. The man was seen on two further occasions by nurses as the symptoms persisted. Both nurses prescribed painkillers but did not refer him to the doctor.

Just over a month later, whilst in the prison library on 7 September, the man became unwell with chest pain. An ECG was performed that indicated that, since the previous ECG, there had been changes to his heart rate. As a result, he was taken to hospital by emergency ambulance. He was discharged the following day having been diagnosed with a chest infection for which he was prescribed antibiotics and painkillers.

On 11 September 2007, a nurse was called to see the man in his cell as he was complaining of pain in his lower left lung and his right leg was noticeably swollen. The nurse referred him to the doctor who noted that the man had been diagnosed with a chest infection four days earlier, and thought the swelling in his leg might have indicated a deep vein thrombosis (DVT). The man was again taken to hospital, under escort, and admitted to the High Dependency Unit. During his stay, the prison kept in regular contact with the hospital.

The man was told by doctors on 20 September that he probably had cancer and the diagnosis was confirmed eight days later. His condition deteriorated rapidly and he was told that his life expectancy was only a few days.

The prison contacted the man's relatives to inform them of the situation and advised that, in view of his decline, they might wish to visit him sooner than their planned visit in two days. When the man's relatives arrived at the hospital they were initially refused access to his room as there was no female officer available to search them. After 45 minutes, no female officer had arrived at the hospital so the bedwatch officer allowed the visitors to stand by the man's bedside until the officer arrived. The searching procedures were then carried out.

The man's condition continued to deteriorate and, on 30 September, medical staff requested that his restraints be removed. The duty governor authorised their removal at 10.00am. At 2.25pm, his family visited again and stayed for three and half hours. Staff said that if the man's situation became critical they would contact them. At 9.00pm, medical staff informed the bedwatch officers that the man's condition was critical. His family was contacted and advised to return to the hospital. However, he died shortly before they arrived. The man's death was confirmed at 11.10pm.

After the man's death, the prison chaplain provided support for the family. The chaplain also officiated at his funeral and conducted a memorial service in the prison chapel.

I have made four recommendations and identified two areas of good practice.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 4 October 2007 when my investigator visited HMP Wakefield. She met the then the Governor and a senior manager. My investigator handed over notices and the Ombudsman's terms of reference. Members of the Independent Monitoring Board (IMB) and the Prison Officers' Association (POA) did not wish to meet my investigator. During the visit, she went to C wing and spoke to a friend of the man. She also spoke to the chaplain.

2. My investigator and one of my family liaison officers, visited the man's sister and partner on 12 November at his sister's home. Both family members praised the support of the chaplaincy and members of prison staff for their help and assistance whilst the man was in hospital and following his death. Nevertheless, they raised the following points in relation to the man's medical care and his time in hospital:

    - Can the clinical review comment on the speed of the deterioration in the man's health?

    - Why was the recurrence of cancer not picked up by the six monthly checks?

    - Was the fact he was restrained for most of his stay in hospital reasonable?

    - Why were the family dealt with so rudely when they arrived at the hospital just before the man's death?

3. I have addressed these concerns later in this report. Although issues relating to the care by the hospital fall outside the remit of my report, I will address matters in respect of the prison's medical care.

4. My investigator returned to Wakefield on 19 November 2007 to carry out interviews with staff and prisoners. The following day, she was joined by one of the clinical review panel members, and together they interviewed members of healthcare staff.

HMP WAKEFIELD

5. HMP Wakefield holds male prisoners serving four years or over, including life sentence prisoners. The prison is part of the high security estate, taking those prisoners who potentially pose the greatest risk to the public. It specialises in the treatment of serious sex offenders.

6. The prison provides workshops and an education department offering both full and part-time education. The programmes department offers a range of offending behaviour courses including FOCUS (a drug programme), the Sex Offender Treatment Programme (SOTP), and the Enhanced Thinking Skills (ETS) programme.

7. The most recent report by HM Chief Inspector of Prisons was published in April 2005 after an unannounced follow-up inspection. The report said of healthcare:

> "There had been little change in healthcare facilities since the last report. Wakefield provided 24 hour care for prisoners and had a 20 bed inpatient facility. Staff were enthusiastic and committed to improving services but there appeared to be a lack of strong clinical leadership particularly in primary care area."

8. This is the ninth death my office has investigated at Wakefield since 2004 and the second death by natural causes investigated by my investigator. The previous death investigated by her was in entirely different circumstances to that of the man.

KEY FINDINGS

9. The man was received into HMP Leeds, on remand, in August 2004. On reception, he told staff of a history of skin cancer on his back and that he had recently undergone an operation for the removal of a malignant melanoma (growth), with four stitches remaining in place. He also said he had problems with his blood pressure, chest pain, and a family history of coronary heart disease. The man had an outstanding dermatology outpatient appointment at a hospital in Bradford on 1 September. This appointment was subsequently re-arranged for 20 September. The man attended and was referred to a plastic surgeon.

10. Four days later, a consultant dermatologist at the hospital faxed to Leeds a confidential report dated 6 September. The fax explained the seriousness of the illness and also requested that the information not be disclosed to him. The man continued to receive medical care at Leeds. In September 2004, he was sentenced to seven years and nine months imprisonment.

11. The man transferred to Wakefield on 8 October. His reception health screen document noted his previous medical history, including the removal of the melanoma. The prison medical officer wrote to a consultant plastic surgeon at a hospital referring the man for an urgent appointment as he had been unable to attend a previously booked appointment. He also referred the man to a consultant dermatologist. The man continued with his prescribed medication of atenolol, simvastatin, doxazosin and aspirin, for high blood pressure, high cholesterol and heart related disease.

12. Two weeks later, the man was seen by a plastic surgeon at a hospital who listed him for further surgery on his back. This took place on 4 November at hospital. A diagnosis was given that that there was no residual melanoma and he returned to Wakefield the following day. He attended an outpatient appointment a month later to have his dressing checked.

13. The man was seen regularly in healthcare for medication reviews between November 2004 and June 2007. Whilst his medical notes record some back pain, there are no significant entries. There was no record in the man's wing file with reference to his medical condition.

14. The consultant dermatologist at hospital wrote to the prison medical officer on 16 February 2005 to confirm that there had been no recurrence of the skin cancer, no lymphadenopathy (swelling of the lymph nodes), and nothing else of concern following the surgery in November. The man attended an outpatient appointment the following day at the plastic surgery clinic.

15. Following further reviews with the man, the consultant dermatologist subsequently wrote to Wakefield in June and October 2005 to confirm that there had been no recurrence of the melanoma or lymphadenopathy. In June 2006, the consultant saw the man again and noted, in a letter to the medical officer, that there were no problems regarding the melanoma on his back. The naevus (a small dark spot of skin) was unchanged and there were no worrying features when he was examined through a dermatoscope (a hand held optical device for examination of the skin). The man was to be seen again in four months time.

16. On 20 June 2007, following another outpatient appointment, the consultant dermatologist informed the prison medical officer that there were no continuing problems and the man would be discharged from the clinic after his six-month review.

17. The man went to the first contact clinic in the prison's healthcare on 3 July. His left leg was swollen between his ankle and knee. An urgent referral was made and, a week later, he was seen by the doctor who prescribed medication and advised the man to raise his leg on two pillows at night.

18. Healthcare staff saw the man again on 24 July when he reported chest pain, shortness of breath and sweating. He was given an electrocardiogram (ECG) to trace his heart functions. His observations were also noted and showed blood pressure of 176/95 with a pulse rate of 40. The man was taken, under escort, to the Accident and Emergency Department of the local hospital. There is no other information in his medical notes as to the outcome of this referral, but the clinical reviewer points out that this is apparently normal practice for prisoners attending Accident and Emergency.

19. The man's medical record shows that on 6 August he failed to attend a doctor's appointment at the healthcare unit. On 23 August, the man was seen by the nurse. He was complaining of dental pain, some numbness on the left side of his face and a foul taste in his mouth. He was already using paracetamol for pain control and a mouthwash. The nurse noted there was no drooping or swelling of his face. The man was advised to make an appointment with the doctor if the sensation returned.

20. The man had ongoing dental problems with dental caries. On 6 September 2007, he was seen again in healthcare by a nurse who noted in his medical file that he needed to see a dentist urgently and to carry on with the pain control and mouthwash. Unlike the previous nurse who saw him in August, this nurse did not refer him to the doctor.

21. The following day, the man became unwell whilst in the prison library. A code blue alert was made (a communication radio call to

healthcare staff to attend as a matter of urgency) and healthcare staff went to the library. On arrival, the nurse noted that the man was sweating, clammy to touch, short of breath and complaining of central chest pain radiating to the right shoulder. An ECG was carried out that indicated some changes from his previous ECG two months before. The man was escorted to hospital by emergency ambulance.

22. The man was discharged from hospital the following day and returned to his wing on normal location. The discharge information form noted that he had been diagnosed with a chest infection. The man was prescribed antibiotics and pain control. He was also advised to stop smoking, to take exercise and to continue with his regular prescribed medication. By this time the man was having difficulty sitting up in bed and was eating very little. Other prisoners from his wing assisted the man by collecting his food and helping him maintain his personal hygiene.

23. At 8.30am on 11 September, a nurse was called to see the man on the wing. He was complaining of pain in the lower left lung, and his right leg was swollen and noticeably larger than his left. The nurse referred the man to the doctor, who examined him at 10.10am. The doctor noted that the man had been diagnosed with a chest infection the previous week whilst in hospital, and there was gross swelling in his right leg with a very tense calf. The doctor requested an emergency ambulance to take the man to the hospital's Accident and Emergency Department to rule out the possibility of a deep vein thrombosis (DVT). The man was escorted to hospital by two officers under a double handcuff restraint.

24. On arrival at hospital, doctors examined the man and moved him to the High Dependency Unit (HDU) for observation and treatment. On the advice of medical staff, the man's restraints were removed and a single escort chain was used. On 16 September, the man was moved from HDU to a general ward. His partner and sister arranged, through the prison's visitors centre, to visit him that afternoon and during the evening two days later. The man's condition was gradually deteriorating.

25. On 20 September, the man was seen by a hospital doctor who informed him that he probably had cancer. Three days later, he received another visit from his partner and sister, and his two sisters visited him on 26 September. At that point, the man was eating very little and a drip had been inserted to increase his fluid intake.

26. The man was told by a doctor on 28 September that the cancer had spread to his kidneys and his life expectancy was only a few days. The bedwatch officer, informed the control room of the situation and suggested that the man's visitors arrange a visit sooner than the one booked for 30 September. The control room then contacted the

man's partner. It is unclear what the staff member told her, but it seems they did not make it clear that the re-scheduled visit had to be booked in the usual way. As a result, a formal visit was not arranged.

27. The man's partner and sister arrived at the hospital at 1.45pm on 28 September. However, a governor informed them that they would not be allowed to see the man until a female officer had arrived from the prison to search them. At 2.30pm, as the officer had not arrived, the bedwatch officer decided to permit the visitors to see the man, but without any physical contact until they could be searched. The officer arrived at 2.40pm and conducted the search procedure. The visitors left at 5.15pm and were advised to contact the visitors centre to book a time to return the following day. The next day, the man's visitors arrived at the hospital at 2.10pm. The bedwatch officer telephoned the visitors centre to arrange further visits for the family.

28. At 6.00am on 30 September, nursing staff informed the bedwatch escort that the man's condition was deteriorating rapidly and medical staff might shortly request all restraints to be removed. At 10.00am, a governor gave permission for the restraints to be released. The man's partner and sister visited at 2.25pm. At 5.20pm, the bedwatch escort notified the prison that the man's visitors had been allowed to remain by his bedside as his condition continued to deteriorate. The visitors left at 5.50pm, having been informed that if the man's condition became critical they would be contacted immediately.

29. At 9.00pm, medical staff informed the bedwatch escort that the man was close to death. The escort contacted the prison who, in turn, telephoned his relatives to advise them to return to the hospital. Unfortunately, he died at 10.44pm and his death was confirmed at 11.10pm. Five minutes later, at 11.15pm, the man's relatives arrived at the hospital and were met by a governor who told them the sad news.

30. The chaplain visited friends of the man's in HMP Wakefield to tell them of his death. The bedwatch notes indicate that officers were supported by senior managers during the man's time in hospital.

31. The chaplain provided support for the family. He also conducted the funeral service and a memorial service, attended by the man's family, was held in the prison's chapel. While they were at the prison, his family was given to the opportunity to meet his friends. The prison offered the family financial assistance towards the costs of the man's funeral.

ISSUES

Key findings from the clinical review

32. An interim report on the man's medical care was carried out by a panel of clinicians from Wakefield and District Primary Care Trust (PCT). A GP was then commissioned by the PCT to complete the clinical review. The review was based on the man's post mortem report, medical record, interviews with medical staff and copies of his outpatient letters.

33. The GP has noted:

> "…The man had been diagnosed with a malignant melanoma in 2004. The melanoma was treated with surgery in November 2004 with no obvious recurrence. In September 2007, the man was admitted to hospital with chest pain, and a possible deep vein thrombosis (DVT) or pulmonary embolus. He was also found to have a widespread and incurable metastatic malignant melanoma. The man died shortly after the diagnosis."

34. Following the initial surgery, it is normal practice to have further surgery for a much wider excision of the mole. However, the clinical review finds there was a delay in referring the man to the plastic surgeon, so this second surgical procedure did not take place until 4 November. Some of his outpatient appointments had been cancelled for security reasons, though there is no documentation to evidence this other than a handwritten note on the appointment letter by the security governor.

35. Following the second surgical procedure, the man was referred to the dermatologists for reviews of his medical condition and he attended outpatients for six monthly reviews. At the first review, a consultant dermatologist said he would have wished to refer the man for trial therapy to treat the deep melanoma found during the first surgery in July 2004. This did not take place as the referral should have been made within eight weeks of the surgery.

36. It was considered that the man was at risk of developing coronary heart disease, but it is difficult to ascertain from his written medical record the overall assessment of this risk and any steps taken to prevent it. The man had multiple blood pressure readings and was treated with atenolol and doxazosin, which are anti-hypertension medications. In addition, he took simvastatin, a cholesterol reducing drug, but the dosage was altered at times and it seems the man took this medication intermittently. The drug prescribing record is also inadequate.

37. The man suffered chest pain on 24 July 2007, thought to be coronary, and was treated with aspirin and oxygen. He was

admitted to hospital but returned the same day. There is no discharge letter in the man's medical records so it is not possible to know how the hospital viewed his presentation or investigations. There is no record of any advice given or any medication dispensed at the discharge. Neither is there evidence of any assessment on the man's return to prison.

38. On 7 September 2007, the man had further possible cardiac chest pain and he was again taken to hospital by emergency ambulance. He remained in hospital overnight and blood tests were carried out. Later that day, he returned to Wakefield with a diagnosis of a chest infection and a prescription of amoxicillin, an antibiotic. No follow up was arranged and the man was returned to his cell.

39. Three days later, the man presented with further chest pain and a swollen right leg, thought to be a deep vein thrombosis (DVT). An emergency ambulance was called and the man was taken to hospital. On 21 September, it was determined that he had cancer and he was referred to the cancer services. As noted earlier, the man died at 10.44pm on 30 September.

Issues arising from the key findings

40. The man's medical records show a significant variation in the legibility of information recorded and ownership of many of the entries. It significantly impeded an assessment of his hypertensive care. A new computerised system was introduced to Wakefield on 1 August 2007 that led to a substantial improvement with legible entries and accurate dating. The doctors have passwords to enter the system with meaningful and specific entries in their name. The clinical reviewer notes that:

> "The doctors had a good understanding of the need to record accurately with sufficient detail to allow the team caring for prisoners to be sufficiently informed as to make important decisions if needed."

41. Prior to the man's imprisonment, he had undergone a localised excision of a melanoma of two millimetres or more in depth. This carried with it a 25 per cent risk of microscopic spread. It is not known whether the delay in referring him for a wider excision increased the risk of metastatic disease, but the delay did exclude the man from the entry criteria for trial medication. Standard General Practice would aim for a two week period between initial presentation of a suspicious lesion and its excision. The expectation would be for wider excision to be carried out within a short period of time. This timescale was clearly not provided for in the man's case. The GP says he understood that the appointments made for the man whilst he was at Leeds were stopped on security grounds, but there was no evidence of any discussion with medical

staff as to the need for the outpatient appointments or indeed a timescale for them.

42. The man's medical record included a letter from his solicitor dated 26 August 2004. The letter requested that the man attend his outpatient appointment on 1 September. A security governor at Leeds had made a handwritten note on the letter that the man could not attend the appointment because the fact he was aware of the date and time made him a high security risk. Another appointment was booked for 8 November. My investigator contacted the security department at Leeds but they held no records for the man.

43. Although this cancelled appointment occurred at Leeds, it would appear that within the primary healthcare setting in Wakefield there is no clinical lead for cancer patients, no register of cancer patients, and no system for auditing the decision making processes around appointment planning. At interview, the doctors did not consider it was their role to interfere in the appointment planning process.

44. I endorse the following recommendations taken from the clinical review:

The Primary Care Trust should appoint a lead clinician. Clinical leads should be identified to provide leadership and governance on important clinical areas such as cancer care and chronic disease management. This should be supported by the development of the Primary Care Team and management changes to support these developments.

A reassessment of referral arrangements should be carried out. An up to date list of referrals with auditing to ensure attendance, transport and escorts are all in place. Cancellation of arrangements made within a prison should be flagged up and assessed against the clinical needs of the patient. A clinical lead may be necessary to ensure that medical factors are sufficiently weighed by all parties when making arrangements regarding hospital attendance.

45. The management of the man's hypertension was generally effective, in that multiple blood pressure results showed that he was largely kept within the normal range. The introduction of the computer medical record system should allow for better documentation, both in issuing medication and the registration of risk factors, blood pressure, cholesterol, weight and smoking. The system should allow for the pro-active making of appointments as well as auditing patients who do not return for routine screening.

46. The management of the man's acute admissions seems to have been relatively smooth with admissions to Accident and Emergency being justified. However, The GP raises concerns about the man's

rapid return to prison having being referred with a potentially significant illness and it seems he was not reassessed on his return to Wakefield. There did not seem to be any regular system of reassessment, or any prior discussion with hospital staff before a patient was discharged, to ensure the hospital understood the prison's requirements. There was no assessment of the man's placement in the prison on his return. Without such an assessment, there is a risk of patients returning to a cell area whilst unfit to be there, particularly at nights and weekends. There appeared to be only one discharge note received following his two attendances at the hospital.

47. The GP questions whether the man's discharge on 8 September was appropriate, given his relatively rapid re-admission. He also wonders whether at that time the man had a chest infection or a pulmonary embolism, based on his ECG change and the post mortem findings. The GP considers that the whole area of communication around the discharge of potentially significantly ill prisoners needs to be assessed.

48. I endorse the following recommendation taken from the clinical review:

I recommend that the arrangements for the return of a prisoner from hospital allow for a proper assessment of the prisoner's continuing needs. This would include a proper assessment of continuing symptoms, the need for appropriate medication and a suitable location within the prison. This should be available both out of hours and during normal working hours.

Family issues

49. On 12 November 2007, my investigator and one of my family liaison officers visited the man's sister and his partner. Both said that the prison had supported them following his death, and they were grateful to the chaplain for his assistance in helping to arrange and officiate at the man's funeral. The issues they raised about the deterioration in his health and the recurrence of his cancer have been discussed within the clinical review and the main body of this report. The remaining questions about the man being restrained in hospital and the handling of his family are dealt with below.

Restraints

50. The man was a category B prisoner held at a high security prison. He had been convicted of serious offences but had not been able to participate in any relevant offending behaviour programmes as he had denied his offences. Moreover, as the man was formerly a locksmith by trade, this raised significant security issues. Wakefield has a local security instruction manual. The instruction regarding restraints for prisoners in outside

hospital says: “The prisoner must in normal circumstances be secured to one of the officers by means of mechanical restraints. The risk assessment will indicate whether this will by double handcuffing or escort chain only.” The man’s risk assessment before he was admitted to hospital on 11 September noted that he had previously been on the E-list (escape list) due to his previous occupation as a government locksmith. The man’s restraint was an escort chain.

51. At the request of medical staff, and duly authorised by a governor, the escort chain was removed at 10.00am on the day the man died. His condition was deteriorating rapidly and any further use of restraint was clearly inappropriate. Whilst I entirely understand the family’s distress that restraints were used until twelve hours before the man died, staff were following the prison’s security manual on the use of restraints for category B prisoners and the prison regarded him as being at increased risk in view of his former occupation. I think these were not unreasonable judgements in the circumstances.

52. I frequently comment on the difficulty facing prisons in balancing the need for public protection and the compassionate management of seriously ill or dying prisoners. In several recent reports, I have been critical about the lack of flexibility in local policies on bedwatches. The Prison Service accepted my recommendation in a previous report about the need for explicit instructions on how to manage gravely ill or dying prisoners in outside clinical environments. In addition, a review of the use of restraints during hospital escorts and bedwatches has been undertaken following the case of G in the High Court in November 2007. The policies within the Prison Service’s National Security Framework (NSF) have been amended to take account of prisoners who are seriously or terminally ill and the need to balance their changing physical condition against the need to provide the public with adequate protection. In view of this, I make no further recommendation.

Events on 28 September 2007

53. Both the man’s sister and partner were unhappy with the reception they received on arrival at hospital in the early afternoon of 28 September. They both felt that a member of prison staff spoke rudely to them when they arrived to see the man, following information that he was very ill. The member of staff has been identified as a governor who was carrying out a management and security check at the hospital. The governor was unaware that the man’s relatives had arrived at the hospital and there was no female officer to carry out searching procedures on the visitors.

54. The bedwatch officers made contact with the prison and requested a female officer to attend the hospital as soon as possible to search the man’s visitors. Unfortunately, this was over lunchtime and it took some time to identify an officer and dispatch her to the hospital. Both

the man's relatives had to remain outside the ward to wait for the officer to arrive. The relatives became anxious and they felt the governor was unsympathetic, rude and failed to recognise their distress.

55. The governor responded to my enquiry to give his version of the incident. He told me that he was not aware that the man's family had been contacted by the prison to inform them of the man's deteriorating condition. A female officer had not been told to attend the hospital and, when he became aware of the situation, he made sure the prison was sending someone as soon as possible. The governor thought that one of the relatives became angry at having to wait for security searching, but said that he apologised to them and expressed his sympathy concerning the man's medical condition.

56. The local security instructions for bedwatches say:

> "Visits to prisoners will be booked in the usual way by phoning the prison visits booking number. (Visits booking staff will tell the prisoners visitors that no money, property or food will be taken for the prisoner.) This will allow the Security Department to ensure that the correct staff are available for searching purposes i.e. a female officer to search female visitors etc."

57. It was understandable that the man's relatives were upset when they arrived at the hospital and told they could not see him as there was no officer to carry out searching procedures. They had been telephoned by the prison and had been told he was very ill. They were asked to arrange to come and see him before the next visiting time, booked for Sunday 30 September. All visits to Wakefield prisoners in hospital are arranged through the visitors centre and are in accordance with usual visiting patterns for a prisoner. I understand that the governor had not been alerted to the situation and was therefore surprised to see the man's relatives at the hospital ward. However, this was a sensitive situation and, whatever exactly passed between them, communication between the prison and the man's relatives was unsatisfactory. I therefore recommend that the Governor ensures that, where a prisoner is on bedwatch at an outside hospital, and becomes very ill, a family liaison officer is asked to make visiting arrangements on their behalf.

The Governor should ensure that the local security instruction manual is amended to include guidelines for informing relatives of prisoners who become terminally ill at outside hospital, and arrange for a family liaison officer to make suitable visiting arrangements on their behalf.

Family response to draft report

58. The man's partner responded to the draft report and noted that the man did not see a dentist even though an urgent appointment was requested for him to see a dentist. She further noted that the man did not seem to have a full medical assessment when he returned to the prison following an emergency admission to hospital.

59. The man's partner felt the legibility of the medical records were poor and concluded her response by noting that in her view her partner would have received better treatment in the community for his condition.

60. The man's sister also responded to the draft report. She noted the poor standard of written medical notes. The man's sister questioned the time her brother waited to see the doctor on the 11 September, after being seen by the nurse. To clarify this point, the doctor saw her brother as soon as practicable after he arrived for his duty at the prison that morning.

61. A second point raised by the man's sister referred to her brother saying he was on the wrong medication as noted in an annexe. I am unable to comment on this point other than it may have been the man's own opinion on to what he was being prescribed. All his prescribed medications were correct for the symptoms he was presenting at the time.

62. The final point the man's sister wished to comment upon was the event on 28 September 2007, when she arrived at the hospital with the man's partner following the telephone call from the prison. The man's sister did not agree with the governor's memory of the meeting outside the hospital ward. She felt that his demeanour was rude and insensitive. The man's sister and partner were confused and upset at the news that he was very ill and the governor did not help the situation by his inappropriate behaviour towards them. This was in complete contrast to everyone else they met, hospital or prison staff.

63. The man's sister thought the recommendation for a family liaison officer to be appointed for seriously ill prisoners was a good way forward nevertheless, her experience that day was less than satisfactory.

64. Finally, the man's sister said how comforted they had felt by the impression that he had been very well liked and respected by both prisoners and staff. They were apparently told this many times when they visited the prison.

Bedwatch

65. With the exception of the incident on 28 September, The man's family were very grateful for the support offered and for the sensitive manner in which the escorting officers carried out their duties whilst at the hospital.

66. The bedwatch notes detail all relevant information whilst the man was an in-patient and were kept in a clear and concise manner. The notes were informative and accurately recorded all the interventions in relation to the man's care.

I note the sensitive way in which the bedwatch officers cared for the man and his family, and the well-recorded bedwatch notes.

Family support

67. The man's family expressed their gratitude to Wakefield's chaplain, for his help and assistance following the man's death. The family was also appreciative of the support from two senior managers for their sensitive approach.

I commend Wakefield's continuity of care following the death of a prisoner, and in this particular case the actions of two senior managers and the chaplain.

RECOMMENDATIONS

For Wakefield Primary Care Trust

1. The Primary Care Trust should appoint a lead clinician. Clinical leads should be identified to provide leadership and governance on important clinical areas such as cancer care and chronic disease management. This should be supported by the development of the Primary Care Team and management changes to support these developments.

   Accepted – This is being processed through the strategic outline plan 08/09 (primary care project); currently recruiting a lead clinician; new operational and clinical management arrangements are being processed.

2. A reassessment of referral arrangements should be carried out. An up to date list of referrals with auditing to ensure attendance, transport and escorts are all in place. Cancellation of arrangements made within a prison should be flagged up and assessed against the clinical needs of the patient. A clinical lead may be necessary to ensure that medical factors are sufficiently weighed by all parties when making arrangements regarding hospital attendance.

   Accepted – An Escorts and Bedwatches (E&BW) project manager is in post. Medical lead to be appointed to carry out clinical audits.

3. I recommend that the arrangements for the return of a prisoner from hospital allow for a proper assessment of the prisoner's continuing needs. This would include a proper assessment of continuing symptoms, the need for appropriate medication and a suitable location within the prison. This should be available both out of hours and during normal working hours.

   Accepted – E&BW project manager in post; lead nurse in post; medical lead to be appointed to carry out clinical audits.

For the Governor of HMP Wakefield

4. The Governor should ensure that the local security instruction manual is amended to include guidelines for informing relatives of prisoners who become terminally ill at outside hospital, and arrange for a family liaison officer to make suitable visiting arrangements on their behalf.

   Accepted - LSS (2.21) to be amended to identify when a prisoner is terminally ill, the Family Liaison Officer (FLO) is contacted to arrange future visits.

GOOD PRACTICE

5. I note the sensitive way in which the bedwatch officers cared for the man and his family, and the well-recorded bedwatch notes.

   Accepted

6. I commend Wakefield's continuity of care following the death of a prisoner, and in this particular case the actions of two senior managers and the chaplain.

   Accepted