Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Whatton, in a local hospital at Nottingham, on 30 November 2008

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

Final report

This is the report of an investigation into the circumstances surrounding the death of a man. The man was 72 years old when he died from natural causes on 30 November 2008 at a local hospital in Nottingham. He was a prisoner in the custody of HMP Whatton.

The man had been diagnosed with lung cancer in the spring of 2007. He managed quite well in the months that followed, but his health declined in 2008. He was placed under the care of a palliative care nurse because it was recognised that his illness was terminal. The cancer began to spread to other parts of his body. He underwent a course of chemotherapy to slow the spread of the disease, but this left him feeling weaker. He died as a result of neutropenic sepsis (meaning that an abnormally low number of white blood cells in his body led to him developing an infection and then a fever). This is a recognised complication in patients receiving chemotherapy.

I would like to offer my sincere condolences to the man's wife and to all those affected by his death. I understand that the man's wife was able to spend time with her husband during a visit on the day he went to hospital, and that she was also able to be at his bedside when he died the next day. I hope that this has provided her with some comfort.

I would like to apologise for the lengthy delay in issuing the final version of the report. The investigation was completed by one of my investigators. My former Senior Family Liaison Officer contacted the man's wife to discuss my investigation and the questions which she had about her husband's death. Another of my Family Liaison Officers has maintained contact with the man's wife.

A clinical review of the treatment which the man received in custody was undertaken by Dr A on behalf of NHS Nottinghamshire County. He has assessed whether the care that the man received in custody was comparable to that he would have been offered in the community. I am grateful to Dr A for his assistance. (A copy of his review is annexed to my report.) I would also like to thank the Governor and her staff and prisoners at Whatton for their full cooperation whilst my investigation took place. I especially acknowledge Ms C, who liaised with my investigator and organised the interviews.

The man had spent several years in custody before his illness was diagnosed. Whilst his death was expected within weeks, my investigation has determined that more might have been done to prevent the final infection that caused his death. Had he been treated more proactively, he might have lived a very short while longer. In particular, I have highlighted the vulnerability of prisoners who are receiving a course of chemotherapy. I make one recommendation in relation to the use of restraints. I also note the number of times that hospital appointments were cancelled because of a shortage of prison staff to act as escorts.

Jane Webb
Acting Prisons and Probation Ombudsman **December 2010**

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SUMMARY

The man arrived at HMP Nottingham on 10 January 2003. A few weeks later, on 4 February, he transferred to nearby HMP Whatton.

As a long term smoker, the man was advised to give up in 2005 when he became increasingly short of breath. In February 2007, he started to cough up blood. The following month, he was assessed during a stay at the local hospital in Nottingham. On 30 March, he was told that he was likely to have lung cancer, and a two week referral was made (the NHS promises to assess all patients suspected to have cancer within a fortnight).

Having missed an appointment on 10 April because prison staff were unavailable to escort him to the hospital, the man underwent further tests later that month. He was due to attend an appointment on 1 May, but again prison staff were unable to accommodate the hospital's request. The man made four visits to the hospital later that month, and following further exploratory tests was told that he might undergo an operation to remove his diseased right lung.

With a view to surgery, further hospital appointments were organised for 11 and 21 June to allow for pre-operative tests to be carried out. However, the prison was unable to supply the necessary staff to escort the man to hospital, and he missed both appointments. On 22 June, a consultant wrote to the healthcare team at the prison to say that the failure to bring the man to his appointments was jeopardising his chances of successful treatment.

When the man attended appointments on 26 June and 2 July, it was decided that the tumour in his lung was now inoperable because it was too close to his windpipe. It was instead decided that he would begin a course of radiotherapy to slow the growth of the tumour. Between 29 July and 11 August, the man stayed in hospital for radiotherapy treatment.

Over the next year, the man became gradually frailer. It was recognised that the cancer could not be successfully treated, and he was therefore placed on the palliative care register. (Palliative care is treatment which seeks to reduce the severity of the patient's symptoms, because it is recognised that the disease cannot be cured.) The man maintained some of his mobility, but by the summer of 2008 he had become weaker and had to use a wheelchair more frequently.

At the end of October 2008, the man began chemotherapy treatment after it was found that the cancer from his lung had now spread to his liver. However, the chemotherapy weakened him further and made him feel unwell. In the middle of November he moved to a specially equipped cell where his wife could visit him.

On Saturday 29 November, the man was visited by his wife. Afterwards, his condition deteriorated. Nurse A consulted with the out of hours doctor, who liaised with the Oncology Department at the local hospital. Nurse A was advised by the doctor that the man would be admitted to hospital, and at 3.41pm an ambulance was requested on a 'within an hour' basis. Later in the afternoon, the man's temperature had risen above normal limits.

The ambulance did not reach Whatton for 90 minutes, meaning that the man eventually arrived at hospital at 6.45pm. He was visited by his wife in the evening and his condition deteriorated overnight. At 5.45am, the escorting officers were asked by hospital staff to remove the restraints. The man died an hour later, with his wife by his side. The cause of death was neutropenic sepsis (blood poisoning), resulting from a weakened immune system caused by his chemotherapy treatment and his ongoing lung cancer.

My investigation has raised some concerns. Prison staff failed to escort the man to four appointments whilst he was being diagnosed in 2007. When he was eventually brought to the hospital and tests were completed, the tumour in his lung was found to be inoperable. I am satisfied that the new Head of Healthcare has made substantial improvements to the appointments system.

I express concern about hand-cuffing the man in hospital until an hour before he died. I do not consider that this was either necessary or respectful. I understand that a previous recommendation that I had made regarding the cuffing of prisoners is now being implemented, albeit after the man's death. I make one recommendation in the hope that the unnecessary use of restraints does not occur in the future.

Although my investigation is critical in some respects, I have been impressed by the efforts being made by the Governor, wing and healthcare staff to address the needs of the increasing numbers of chronically ill, elderly prisoners at Whatton.

THE INVESTIGATION PROCESS

1. My investigator was formally notified of the man's death on 3 December 2008. Notices were subsequently issued to both staff and prisoners at HMP Whatton, informing them of the investigation process and giving the opportunity to contact my investigator if they felt that they could provide any relevant information. No prisoners came forward, but when he visited Whatton my investigator was able to speak informally with two of the men who helped to care for the man.

2. My investigator made contact with Ms C, the prison's liaison officer. She provided him with all records relating to the man's time in custody and organised the interviews subsequently conducted at Whatton.

3. Having examined all of the relevant documents relating to the man's time in custody and the medical treatment he received, my investigator arranged to visit Whatton on 6 February 2009. He interviewed one of the governors and the doctor who oversaw the man's treatment. My investigator returned to Whatton on 23 February to complete interviews with the Head of Healthcare, a nurse specialising in palliative care, and two prison officers. He subsequently interviewed two other prison officers and a nurse over the telephone.

4. My investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation, and to request a copy of the notes made by the doctor on duty at the time of the man's death. HM Coroner will be provided with a copy of my report.

5. My investigator contacted NHS Nottinghamshire County and asked that a clinical review be carried out with regard to the medical treatment which the man received in custody. The purpose of this review is to establish whether the care which the man received in prison was comparable with that he would have been offered in the community. Dr A completed the review, which is annexed to my report.

6. On 17 December 2008, my then Senior Family Liaison Officer wrote to the man's wife providing information about my investigation. She telephoned the man's wife on 5 January 2009 in order to discuss the questions and concerns which she had about the circumstances surrounding her husband's death.

7. The man's wife wanted to know more about the reasons why her husband was not granted early release on compassionate grounds and could not come home to her when he was very unwell. (The interviews which my investigator conducted reflect the fact that early release on compassionate grounds is still very much the exception rather than the rule. This appears to be largely due to the nature of the offences committed by the prison's population.) She also wondered if she could have been permitted more privacy with her husband before he died. I endeavour to address these issues in my report, which I hope gives the man's wife a better understanding of what occurred.

8. **HMP WHATTON**

9. HMP Whatton is a category C training prison which holds men who have committed sexual offences. In recent years the prison's population has doubled, and its maximum operational capacity is now 841. In general, prisoners at Whatton are much older than the prison population as a whole. They may also have been convicted of a sexual offence many years after it took place. This was true in the man's case.

10. Since April 2004, I have investigated 15 deaths at Whatton. Of these, 12 were as a result of natural causes. Three of my earlier investigations raised concerns which I return to in this report.

11. In the case of a prisoner of a similar age to the man whose death in June 2007 was also caused by lung cancer, I recommended that a palliative care policy be implemented. I am pleased to say that my investigator observed good progress in this regard during his visits, and I understand that the palliative care needs of prisoners are now being met by a dedicated nurse. The man benefited from some of these improvements during his illness.

12. When another prisoner died of lung cancer in August 2007, I addressed the use of restraints when prisoners are escorted to hospital. I recommended that a full risk assessment and an assessment of the use of restraints be performed in these circumstances. I repeated my recommendation when I investigated the death of another prisoner in July 2008. Although I am critical of the decision made with regard to the cuffing of the man when he was taken to hospital on 29 November, I am pleased to note that the prison's Local Security Strategy has been updated since he died. It now reflects the need for a more flexible and 'common sense' approach to cuffing.

13. With regard to healthcare provision, nursing staff are on duty from Monday to Friday between approximately 7.30am and 7.30pm. Amongst a variety of tasks, they complete the reception of new prisoners, run clinics and triage prisoners. Different nurses have specialist training in areas such as the management of terminal illness. Doctors from local practices also hold surgeries each weekday. During the weekend, nursing staff work from approximately 7.30am until 2.30pm. During out of hours periods, nurses and prison officers can contact the Nottingham Emergency Medical Services (NEMS). (This is an out of hours service which provides medical advice and allows nurses and prison officers to speak with a doctor to decide whether an ambulance should be called. It is the same out of hours service that the general public would call.)

14. HM Chief Inspector of Prisons carried out an announced inspection of Whatton in January 2007. She acknowledged 'a dramatic and rapid period of change' at Whatton. As far as a palliative care strategy was concerned, none was in place at the time of the inspection. HM Chief Inspector of Prisons recommended the development of such a strategy.

15. Having spoken with various members of staff at Whatton, my investigator has found that progress has been made in this regard over the last couple of years. The management team has introduced several innovations, and there is a recognition that the ageing population makes particular demands on staff that other prisons may not experience.

16. The most recent annual report published by the Independent Monitoring Board (IMB) at Whatton covers the year from June 2007 to May 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB report indicates that the wheelchairs used at Whatton are in poor condition and short supply. They are also not meant to be used outside, which is problematic as most units stand alone and prisoners must be pushed for short distances in the open air in order to reach other parts of the prison. The IMB commends the 'professional dedication' of a healthcare team who are caring for the oldest population of any prison in England and Wales.

KEY FINDINGS

17. The man arrived at HMP Nottingham on 10 January 2003 having received a ten year prison sentence at the Crown Court. He underwent an initial health screening in the reception area and did not report any significant health concerns. He was prescribed amitriptyline (an anti-depressant) to treat his anxiety.

18. Just over three weeks later, on 4 February, the man was transferred to nearby HMP Whatton and a second health screening was completed. Again, no significant health problems were highlighted.

19. The man remained at Whatton and, in March 2004, went before an Incentives and Earned Privileges (IEP) review board, becoming an enhanced prisoner. (The IEP scheme seeks to encourage and reward cooperative and constructive behaviour by prisoners. Prisoners can either gain or lose certain privileges, depending on their actions. Enhanced is the highest of the three levels of the scheme.)

20. Just over a year later, in July 2005, the man underwent a spirometry test (which can help to diagnose a variety of lung conditions). The test confirmed that the man's lungs were working poorly. In late December 2005, as a long term smoker the man was advised by healthcare staff to stop smoking altogether or reduce the amount he smoked. It was noted in his clinical record in November 2006 that he became breathless, particularly after walking short distances. He was unable to breathe comfortably when he was lying down. Three months later, on 5 February 2007, he told healthcare staff that his chest felt tight and he had been coughing up dark yellow sputum.

21. The first indication that the man had a serious illness came a few weeks later on 27 February. He attended the over-65s clinic and reported that he had been coughing up blood in his phlegm and was experiencing more breathlessness. It was planned that these symptoms would be assessed by a member of the healthcare team in March. Two weeks later, on 13 March, The man went to the healthcare centre after coughing up a lump that was 'filled with blood'. He provided a sample of the blood-tinged phlegm, which was sent for tests.

22. Between 19 and 27 March, the man stayed at the local hospital in Nottingham. During this period a chest x-ray was taken which gave cause for concern and further investigation was recommended. On 30 March, the man was informed by healthcare staff at the prison that his likely diagnosis was cancer. A 'two week wait' urgent cancer care referral was made (this meant that the man should be assessed by a specialist within two weeks).

23. The man was offered an appointment with a specialist on 10 April. However, the prison was unable to provide staff to escort him to hospital on that date. Instead, he visited the local hospital later than planned on 17 April. A malignant tumour was suspected and further tests were arranged. Two days later, on 19 April, the man underwent a bronchoscopy. (This is an

examination of the patient's airways using a device which is inserted through either the nose or mouth. Ideally, a small tissue sample is taken from the lung for analysis during this procedure.)

24. About a week later, on 25 April, a computerised tomography (CT) scan confirmed that the man had a malignant tumour in his right lung. (This type of scan helps medical staff to see what is happening inside a patient's body.) It was decided that he would undergo a positron emission tomography (PET) scan. (The scan produces a three dimensional image of the patient's body to assist diagnosis.)

25. Prison officers were unavailable to escort the man to hospital on 1 May, and he therefore missed another appointment. However, the man did go to his hospital appointments on 9 and 16 May. During the latter visit, the PET scan was carried out at the Combined Lung Oncology Clinic and more lung function tests were ordered. The man was told that, as the result of this scan was 'favourable', he might undergo an operation to try and remove the tumour. A couple of days later, the man spoke with healthcare staff at the prison and expressed a wish to stop smoking.

26. Further hospital appointments followed. On 24 May, an isotope lung scan was carried out to check on the blood and oxygen supply to the man's lungs. He was told on 30 May by a thoracic surgeon (a specialist in problems associated with the lungs) that he might undergo surgery to have his right lung removed (referred to as a right pneumonectomy) or start intensive radiotherapy. If his condition remained untreated, the man was told that he had a life expectancy of between six and eight months.

27. With a view to potential surgery, the man was due to undergo a pre-operative bronchoscopy on 11 June. However, he did not attend his appointment because officers were again unavailable to escort him to hospital. After his case was discussed at a hospital meeting on 15 June another appointment was offered for 21 June, but again the prison was unable to provide an escort.

28. On 22 June, Mr A (a consultant and specialist registrar in thoracic surgery at the local hospital in Nottingham) wrote to the Head of Healthcare at Whatton expressing his concern regarding the prison's failure to bring the man to two pre-operative assessments. It seems that hospital staff had just been told by prison staff that the man could not be escorted to another appointment until 19 July. It was thought by hospital staff that such a delay was unacceptable. In his letter, Mr A commented:

> '… if this [situation] is not resolved immediately then the man may have lost the chance for any potentially curative surgery!'

29. I explore the reasons for the repeated failure to escort the man to his hospital appointments in the Issues section of my report. Mr A's letter included the offer of another appointment. The man was taken to a pre-operative exploratory assessment at the local hospital on 26 June. (He again made an application to the healthcare team at the prison on the same day asking for

help stopping smoking.) His case was discussed at a hospital meeting the following day. It was thought that the man was 'borderline for surgery' and should be seen by the oncologist.

30. Following receipt of the letter from Mr A, Ms D (the then Head of Healthcare at Whatton) spoke with Governor A on 28 June. She wanted to ensure that the man would be taken to his next appointment on 2 July, as it seems to have been in doubt. It was agreed that he could attend the appointment. On 29 June, the man was advised that he would start a course of ferrous sulphate to treat his anaemia (a lack of red blood cells leading to feelings of extreme tiredness, because insufficient oxygen is circulating around the body).

31. The man went to the appointment on 2 July and underwent an oral endoscopy (during which a tube is inserted through the mouth to examine the patient's internal organs) and a bronchoscopy to help the hospital staff decide how to treat him. He was told that surgery was not the best option because the tumour was sufficiently enlarged as to be too close to his windpipe. This meant that removal of the tumour (an operation known as a pneumonectomy) was impossible, as other organs were in the way and could be damaged during an operation.

32. Dr B (consultant thoracic surgeon) referred the man to Dr C (Head of Service, Oncology Department, Nottingham University Hospitals) on 4 July, confirming that his cancer was advanced and inoperable. The letter suggested that the Oncology Department should take over the man's treatment. Following a meeting of hospital staff the same day, radiotherapy was planned instead in order to shrink the tumour and manage the spread of the cancer. This form of treatment is known as Continuous Hyperfractionated Accelerated Radiotherapy.

33. Ms D spoke with Governor A again on 5 July to ensure that the man would be able to go to his next appointment four days later on 9 July. He did attend and was assessed by a consultant who arranged radiotherapy.

34. On 6 July, hospital staff noted that the timeframe within which the man's treatment was supposed to start had passed. The delay was said to be caused by the prison failing to escort him to his appointments. It was recorded that the tumour was now inoperable and that radiotherapy was to be arranged instead.

35. A further hospital visit was scheduled for 19 July, but the man did not leave the prison that day and his clinical record indicates that the appointment had to be cancelled. A further hospital visit took place on 23 July.

36. The man fell in the shower on his wing on 27 July. He was examined by healthcare staff but had not sustained any injuries.

37. The man stayed in hospital between 29 July and 11 August for radiotherapy treatment, which aimed to shrink the tumour.

38. Later that month, on 15 August, staff started to blend the man's food as he was having trouble swallowing. However, he did not like the blended food, and two days later asked that staff stop doing this.

39. The man became unwell on 20 August due to vomiting and diarrhoea. His vomit contained traces of blood and it was suspected that this might be the result of food poisoning. Staff were told that the man should be admitted to hospital if he vomited a large amount of blood during the night. However, the following day he felt much better.

40. During a journey to a hospital appointment on 10 September, the taxi escorting the man was involved in an accident when the vehicle was bumped from the rear by another car. When he arrived at the hospital, a chest x-ray was taken and indicated some improvement in the rate of deterioration in the man's condition. It was felt that he had tolerated the course of radiotherapy well and that his cough had improved.

41. A few days later, on 15 September, the man felt too unwell to see his wife in the visits room. Prison staff called the out of hours NEMS (Nottingham Emergency Medical Services) helpline because he complained of chest pain and was coughing up blood. He was given antibiotics and steroids and was visited by his wife the next day.

42. On 3 October, the man was assessed in the healthcare centre. He said that he had started smoking again due to the stress of his upcoming parole hearing. He was anxious after receiving a letter indicating that he could be deported to the Republic of Ireland on his release from custody. The man told staff that he had been experiencing a pain in the left side of his neck following the traffic accident on 10 September.

43. The man went to further hospital appointments on 8 and 12 November. He was told during the latter visit that, whilst the cancer was not in remission, he should not be overly concerned about the immediate situation. He was told to attend a check-up appointment in three months time.

44. On 15 November, the man was examined by a prison doctor. There was concern about his medication because he had been waking up in the night short of breath. A home oxygen cylinder was ordered to reduce his breathing difficulties.

45. Five days later, on 20 November, the man vomited and collapsed in his cell. He was taken by ambulance to the Accident and Emergency Department at a second local hospital. Previously he had attended appointments at the other main hospital in Nottingham. He was subsequently moved to the local hospital, and returned to the prison on 3 December. At this point, whilst he was using oxygen to assist his breathing, he was also still smoking.

46. As part of improvements made by the healthcare team, in January 2008 Nurse B was given responsibility for the treatment delivered to patients with

palliative care needs. The man's care was managed by Nurse B and Dr D, who was familiar with the issues surrounding terminally ill patients.

47. The man was placed on the palliative care register and was treated according to the guidelines set out in the Liverpool Care Pathway. (This is a recognised model of caring for patients whose illness cannot be cured. The intention is that treatment should be comparable to the type which people receive in a hospice.) The man's case was reviewed at monthly multi-disciplinary meetings involving both the healthcare and prison staff.

48. On 10 January 2008, the man was told that his first parole request had been refused. In early February, he received a final warning after repeatedly smoking in the vicinity of his oxygen cylinder. At about the same time he developed a chest infection.

49. The man was taken to the healthcare centre in a wheelchair just before 3.00pm on 11 February. He had woken up in the early afternoon with severe chest pain. Paramedics transferred him in an ambulance to the Accident and Emergency Department at the second local hospital at 5.15pm. He was given drugs to prevent a clot from forming in his blood, although tests confirmed that he was not experiencing a heart attack, as had been suspected. He returned to Whatton on the following day. He attended a scheduled appointment at the local hospital a fortnight later, on 25 February.

50. Between 3 and 6 April, the man's condition was reviewed by the prison doctor each day because he had another chest infection. In early May, healthcare staff noted that the man was experiencing disorientation with regard to the time of day, as well as confusion and memory loss. It was thought that the lung cancer might have started to spread to his brain. On 28 May, a physiotherapy assessment confirmed that the man remained both mobile and independent.

51. The man continued to visit the local hospital regularly. He was escorted to his appointments twice in June and three times in August. During this period he became generally frailer and less mobile. He had started to use a wheelchair to make the journey from his cell to the visits room to see his wife. He could still walk with the aid of a stick, but managed ever shorter distances. He had been given a special chair in his cell and needed some help from other prisoners to carry out daily chores such as making his bed. He also continued to lose weight as the cancer became more advanced and his health deteriorated.

52. On 24 July, the man developed a further chest infection and was prescribed steroids and antibiotics. Two months later, on 15 September, it was noted in the man's medical record that he should have been sent to the hospital the week before for a CT scan. He eventually went to the hospital on 6 October and the procedure was carried out.

53. A fortnight later, on 20 October, because recent blood tests showed a raised potassium level, the man was taken into hospital and kept in overnight for

observation. He returned to the prison the following day. Whilst at the hospital's Oncology Department, he had been told that his lung cancer had now spread to his liver. Plans were made for him to undergo chemotherapy in an attempt to slow down the effects of the cancer, and he was advised of the possible complications of this treatment.

54. At the end of the month, on 30 October, the man began the course of chemotherapy but was exhausted afterwards. The healthcare staff established a protocol whilst the man was receiving ongoing chemotherapy, ensuring that his blood was regularly tested and his temperature checked daily. A note was made in the man's medical record to indicate that, if his temperature rose above normal limits and he became feverish, the hospital was to be contacted.

55. From the beginning of November, Dr D (who had been overseeing the man's treatment) started to visit more frequently. The effects of the chemotherapy were making the man feel unwell. Dr D told my investigator that he had become 'more nauseous, more breathless, probably more frail' from this point. He struggled to walk any significant distance.

56. On 6 November, the man was told that his second parole application had been refused. On the same day he received his next chemotherapy treatment in the prison. Further hospital visits for chemotherapy treatment followed on 19 and 21 November.

57. Nurse B thought that the combination of the refusal of parole and the debilitating effects of the chemotherapy had caused the man to 'go downhill a bit'. In mid-November, he had moved from C1 landing (where he had been a resident for some time) to a larger cell on A8 landing where his needs could be more easily accommodated and he would receive assistance from his fellow prisoners. The man was initially uneasy about moving into a cell where the previous occupant had died.

58. Some of the prisoners volunteer to act as carers, and two of them, Mr B and Mr C, helped the man with everyday tasks such as collecting his meal, opening and shutting his blind, and pushing him across to the visits room in his wheelchair.

59. On 27 November, the man felt poorly, lethargic and was short of breath. Later in the day he was noted to be 'looking very unwell' and had coughed up a small amount of blood.

60. The man's next dose of chemotherapy was administered orally in prison on 28 November as the hospital had instructed. (The man had not eaten for two days, but had been drinking.) Dr D visited the man in his cell the same day. She and the other healthcare staff had observed a decline in his health and mobility since he had begun his chemotherapy treatment, and particularly in the previous ten days.

61. Dr D had been told that morning by the nursing staff that the man 'looked quite unwell' and his lips had turned blue. She told my investigator that:

> '… by the time I got there, actually he wasn't so bad, he was short of breath but not obviously worse, he was still speaking in sentences, his pain was well controlled, he wasn't particularly nauseated, he was using his home oxygen …'

62. Dr D thought that the man's health had declined to a point where she did not think that he was able to get to the visits room to see his wife, even with the use of a wheelchair. She discussed the matter with Governor Phil Aspinall (the duty governor between Thursday 27 November and Sunday 30 November). They decided that from then on the man's wife would be allowed to visit her husband in his cell on the wing. (The cell was designed with a curtain across the entrance to allow privacy whilst an officer remained in the corridor.)

63. The man's wife had the opportunity to visit her husband in his cell on the morning of Saturday 29 November. Practice Nurse A came across to the wing during her morning rounds to give the man his daily medication and examine him. She was aware that he was receiving chemotherapy, and that his body temperature should be checked on a daily basis. If it went above normal limits, she knew to notify a doctor.

64. When Nurse A arrived, she found the man with his wife. She decided to delay her assessment until after the visit, because she knew that they valued the time together and she did not want to interrupt. Before she left, she encouraged the man to take a tablet of Sevredol. (This is a morphine based painkiller which he was to take at his own discretion when he experienced pain.) Officer A sat outside the cell to monitor the visit. As the man's wife left the prison, Governor A told her that he would contact her if there was any change in her husband's condition.

65. Nurse A was concerned about the man following her visit during morning rounds. She felt that he had not looked as well as she expected and had not been his usual self. She had had to help him into his chair.

66. The wing was unlocked after the lunch period and Nurse A returned to the man's cell. She remained concerned and spoke with wing staff. She completed her observations and made a record of her findings back in the healthcare centre at 1.37pm. He complained of chest pain, his blood pressure had dropped, his pulse was elevated but his temperature remained within normal limits (35.8 degrees Celsius).

67. Nurse A rang the out of hours service to consult a doctor between 2.30pm and 3.00pm. She left a message with the operator who told her that a doctor would call her back. Dr E from NEMS returned her call soon afterwards and she described her findings. She told him that the man was unwell and they discussed the need for possible hospital admission.

68. Dr E told Nurse A that he would consult staff at the Oncology Department at the local hospital where the man had received his recent treatment. (Nurse A told my investigator that staff working for the out of hours service are made aware of palliative care patients who are being held in prison.) The nurse remembered that Dr E had said that, on the basis of what she had described, she should make preparations for the man to be admitted to hospital later that day. Nurse A recalled in interview that she and Dr E had discussed the chemotherapy the man had been receiving during their conversation. She made a record of their telephone call at 3.26pm.

69. Nurse A went back to speak with the man in his cell. She asked him whether, if things came to the worst, he had thought where he would like to be. He replied, 'Home'. Remembering the recent refusal of his parole application, she reminded him that this would not be possible.

70. Dr E rang Nurse A back and confirmed that, having consulted with staff at the Oncology Department, he had arranged for the man to be admitted to hospital. According to the call log kept by the East Midlands Ambulance Service (EMAS), an ambulance was requested at 3.41pm. Because it was a planned admission, Dr E made the arrangements, rather than prison staff. The ambulance crew were instructed that the man needed to be collected 'within an hour'.

71. According to the call log provided by EMAS, after the ambulance service was called at 3.41pm, a crew was asked at 4.22pm to collect the man. (This log seems to be the most accurate record of events because it was entered onto a computer as events took place.) The paramedics set off at 4.26pm, and reached the prison at 5.07pm. The ambulance left Whatton at 5.44pm, reaching the local hospital in Nottingham at 6.45pm.

72. In interview, Nurse A remembered going back and forth between the healthcare centre and the man's cell whilst they waited for the ambulance to arrive. She recalled that Officer A, who knew the man quite well, stayed with him whilst she returned to the healthcare centre. Nurse A had been due to finish her shift at 2.30pm, but remained with the man until the ambulance arrived.

73. When she spoke with my investigator, Nurse A recalled examining the man once or twice more before he went in the ambulance. She made one further entry in his medical record at 5.32pm. She noted that his temperature had risen above 37 degrees Celsius (meaning that it was now above normal limits) and that he was not communicating very coherently. She tried to be supportive and encouraged him to keep drinking fluids. When she spoke to my investigator, Nurse A remembered that the man's temperature had 'jumped up' in the late afternoon.

74. The ambulance crew arrived after 90 minutes. Nurse A knew that the paramedics were on their way, but said in interview that it seemed to take a long time for them to arrive. She recalled that she might have made a telephone call to find out how long they would take to reach Whatton.

75. The man was escorted to hospital by Senior Officer Y and Officer A. He was in a wheelchair and was cuffed to one of the officers by an escort chain. (This is a chain approximately eight feet long with a cuff on each end. It allows hospital staff to carry on treating the prisoner without the officer getting in the way.)

76. Governor A and Senior Officer W oversaw the cuffing arrangements. Along with Nurse A, they completed the escort risk assessment. The escorting officers were instructed to remove the chain in the event of an emergency or after contacting the duty governor to obtain his permission.

77. Nurse A completed her part of the Prisoner Escort Record (PER) at 4.45pm, over an hour after the ambulance had originally been called. According to the PER, the ambulance left Whatton at 5.55pm and arrived at the local hospital at 6.40pm. Although these timings differ slightly from the EMAS log, both records confirm that the man did not arrive at hospital until three hours after the ambulance was originally called.

78. In interview, Nurse A said that the man had told her that he was 'comfortable and pain-free' as he left in the ambulance. She talked to him and they shared a joke as he was leaving. She did not recall the precise details of her handover to the paramedics, although she photocopied the man's prescription chart for them.

79. After the ambulance had left Whatton, Governor A telephoned the man's wife to advise her that her husband had been admitted to hospital. He went home and had no further contact with prison staff or the hospital until after the man died. Before she went home, Nurse A called the Head of Healthcare, Ms E, to advise her of the man's admission to hospital.

80. The man was placed in a side room on Fraser Ward in the local hospital. Dr E from NEMS had handed over on the telephone to the hospital staff, briefing them as to the man's current state of health. The man's wife visited between 7.20pm and 9.30pm. Notes made by Dr F after the man died indicated that a 'Do Not Resuscitate' form was discussed with the man's wife before she left and signed by the registrar on duty.

81. The man was diagnosed with neutropenic sepsis. This is an infection and fever caused by a lowered immune system. A localised fever is followed by septicemia (the spread of bacteria in the blood stream, also known as blood poisoning) unless the condition is successfully treated. The patient's immune system is compromised by an abnormally low level of white blood cells. Neutropenic sepsis is a recognised complication which can occur after a patient has undergone chemotherapy. Nursing staff on Fraser Ward recorded that antibiotics were given 'promptly' to the man to try and fight the infection.

82. At about 7.00pm, Senior Officer V and Officer B travelled to the local hospital and took over the bedwatch from Senior Officer Y and Officer A. In interview, Senior Officer V recalled that the man seemed to be aware of them, was able

to speak but appeared lethargic. She was a familiar face, having worked on wing A8. She updated Officer B with regard to the man's health, as he had not worked on wing A8.

83. Dr F's notes confirm that the man continued to deteriorate overnight. Officer B was cuffed to the man. He rang the prison control room approximately every four hours at 7.10pm, 11.05pm and 3.00am. Officer B spoke to the night orderly officer (Senior Officer T) or an Operational Support Grade (OSG) member of staff if she was patrolling the prison. He did not report any significant change in the man's condition to prison staff until shortly before he died. In interview, Senior Officer T could not recall being told of any noteworthy developments until she was telephoned at 5.45am. The cuffing arrangements were not discussed until then.

84. During the night, it seems that hospital staff were very busy, and there was little communication between them and the escorting officers. When my investigator spoke with the escorting officers, they both said that they had not been made aware that the man's death was imminent until shortly beforehand.

85. Senior Officer V noticed that the man seemed to get weaker as the night went on. She described how he became agitated in the early hours of the morning, but settled down after he was given morphine and became 'very, very quiet' after 3.00am. She said that his face seemed to lack colour. Officer B agreed that the man became quiet after 3.00am, and said that he had thought that the man might be dying at this stage but did not share his feeling with Senior Officer V.

86. Officer B made his regular telephone call to the prison at 3.00am. The man was assessed by a doctor at 3.20am. Senior Officer V told my investigator that, at this point, she still did not realise how ill the man was or that his death was imminent.

87. In interview, Senior Officer V was unable to specify the precise time that she and Officer B were told that the man was dying. She commented that the information which she had received from those working on the man had been 'a bit sketchy'. She concluded that they had been told definitively at about 5.30am that he would die imminently and that the restraints should therefore be removed. (Officer B similarly recalled that the hospital staff had spoken to them at about 5.15am, and that this had been the first time that he was given an indication of the seriousness of the situation.)

88. At 5.45am, Officer B removed the escort chain from the man at the request of the hospital staff. He telephoned Senior Officer T at the prison to inform her of his action. She agreed that this was appropriate in the circumstances. In interview, Senior Officer T could not recall consulting Governor A about the removal of restraints. She commented that this decision would normally rest with the duty governor. Similarly, Governor A said that the first time he was contacted by the prison that day was to be told that the man had died.

89. A short while later, having been contacted by hospital staff, the man's wife, sister-in-law and brother-in-law arrived and spent time with him. The man died at 6.45am with his wife at his bedside.

90. Officer B telephoned Senior Officer T and told her that the man had died. She in turn telephoned Governor A, who made his way to the prison. Senior Officer T started the contingency planning which takes place following a death in custody on Governor A's instructions, but shortly afterwards finished her shift. Principal Officer A took over as the day orderly officer.

91. At 7.30am, Nurse A arrived at Whatton to start her shift. She was told that the man had died, and telephoned Ms E to inform her. The man's death was certified at 10.45am.

92. The man's wife visited the prison later to look around. Her husband's belongings were returned to her, and his funeral (which the Prison Service paid for) was held on 16 December.

ISSUES

Failure to escort the deceased man to hospital appointments

93. According to a hospital consultant, the failure of prison staff to ensure that the man was escorted to his hospital appointments delayed his diagnosis and treatment in 2007. He first showed signs of lung cancer at the end of February 2007 when blood was found in his phlegm. Following a chest x-ray at the end of March, he was told that he most likely had cancer. He was offered an appointment on 10 April, but was not taken to hospital because too few officers were available. This appointment was rescheduled for 17 April. Towards the end of that month, he underwent further tests and was informed that he had a tumour on his lung.

94. Once again, a scheduled appointment was missed on 1 May because insufficient staff were available to escort the man to the hospital. He next attended hospital on 9 May. Subsequent appointments were kept, and at the end of May he visited the hospital and was told that he would either undergo an operation or would begin radiotherapy. Prison staff then failed to ensure that he was escorted to two consecutive pre-operative assessments on 11 and 21 June. These appointments were intended to explore the possibility of surgery and help surgeons decide whether an operation could take place.

95. On 22 June, Mr A, a consultant from a local hospital, wrote to the Head of Healthcare at Whatton expressing his concern regarding the prison's failure to bring the man to the two recent appointments. He cited the unavailability of prison staff to escort the man as the reason. As I have quoted earlier, Mr A used unambiguous language in his letter, writing that:

> '…if this [situation] is not resolved immediately then the man may have lost the chance for any potentially curative surgery!'

96. The letter included the offer of another pre-operative assessment. The man was escorted to appointments on 26 June and 2 July. He underwent an oral endoscopy and a bronchoscopy at the latter appointment and was told that the tumour was enlarged, and was therefore too close to the windpipe. This meant that an operation to remove the tumour was not possible, and radiotherapy was planned in order to shrink it instead.

97. Mr A's letter raises concerns that the failure to produce the man from custody on two occasions in June 2007 may have had some impact on the outcome of his treatment. In total, four scheduled appointments were missed during the period of initial diagnosis. Dr A, who completed the clinical review, has raised the possibility that the man's condition became inoperable over the month of June because the tumour was allowed to continue growing. A bronchoscopy (an exploratory procedure prior to surgery) should have taken place on 11 June, rather than 2 July, three weeks later. If one includes the week's delay in April, and another week's delay in May (both a consequence of the prison's failure to escort the man to hospital), then the decision regarding surgery might have been reached five weeks earlier.

98. It is impossible to know whether, had the man undergone the bronchoscopy on 11 June, the tumour might have still been small enough to remove. Other factors have to be taken into account, for example the man's refusal to stop smoking. Nonetheless, the repeated failure to ensure the man could attend his appointments has been acknowledged by Ms E, the new Head of Healthcare who came into post in November 2007. (At the time of the man's diagnosis, Ms D was in post.)

99. Ms E told my investigator that the man was not taken to the appointments on 11 and 21 June because at the time only four prisoners could be escorted out of Whatton each day. (These escorts were in addition to those for court appearances and the like.) Ms E explained that on both dates the four available medical escorts were booked for other prisoners going to scheduled appointments or emergencies. The diary booking system operated at the time meant that the four slots available each weekday were filled up as appointment letters arrived from the hospital.

100. When she spoke with my investigator, Ms E accepted that there had been a failure on the part of the prison to escort the man to hospital. There was little flexibility built into the booking system at the time. The opportunity for healthcare staff to exercise discretion and prioritise a patient diagnosed with cancer seems to have been limited. Ms E agreed that what appeared to have happened was that an appointment was booked, but on the morning itself healthcare staff were informed by the prison that the man could not attend as not enough escorts were available. In other words, a last minute cancellation occurred on two consecutive occasions.

101. Ms E indicated that efforts had been made in liaison with the hospital to reschedule the man's appointments around the availability of escort staff. During interview, she highlighted the complex negotiations required between the hospital and the prison when scheduling treatment. The hospital has limited appointments available, and the prison has to ensure that they have enough staff available to escort the patient.

102. Ms E said that, on both occasions when the man was not taken to hospital, her predecessor Ms D asked for an additional escort to be organised, but her request was refused. She confirmed that, following the letter from Mr A, Ms D spoke with Governor A on 28 June to ensure that the man would definitely be sent to his next appointment on 2 July (which he was).

103. My investigator asked Ms E about the priorities assigned to prisoners requiring medical treatment. She confirmed that in her opinion patients diagnosed with cancer must, without question, be allowed to attend all scheduled appointments. She also indicated that, since she became the Head of Healthcare in November 2007, significant changes had been implemented to improve the provision of escorts for prisoners requiring medical treatment. Nurse B and Dr D both confirmed that considerable progress has been made in the last 18 months.

104. Ms E explained that, under a national agreement in place since April 2008, the Primary Care Trust (PCT) pays for staff escorting prisoners for medical treatment or undertaking a hospital bedwatch duty. She commented that this change has given her greater influence over the provision of escorts and freed the Governor from some financial considerations. Whilst the Prison Governor still has overall control of prison staff, Ms E explained that she and the Prison Governor have developed a positive and constructive working relationship.

105. Consequently, an occasional extra escort can be provided if too many prisoners have appointments or emergencies arise. Ms E can obtain authorisation from the Governor for an overtime payment, allowing extra staff to come into work and an escort to take place. This optional escort is in addition to the two regular medical escorts who leave Whatton each morning during the week, and the two scheduled each afternoon. Ms E also pointed out that the new arrangement allows her to comment on the level of security and restraint used during hospital stays, although the Governor has the final word in these matters.

106. Ms E said that, in addition to a fifth escort if required, some slots in the hospital appointments diary are deliberately kept free until a late stage to build some slack into the system and to accommodate emergencies. As well as improving the booking system, Ms E explained that the introduction of an electronic patient records system in February 2008 has improved the healthcare team's ability to coordinate prisoners' hospital visits.

107. Dr D and Ms E both spoke about the intention to provide terminally ill prisoners with the chance to stay in Whatton as their health deteriorates. The healthcare team are now able to fit prisoners with syringe drivers, meaning that they can receive pain relief as their health worsens. This relatively new development has eased the burden on the daily escorts to hospital and reduced the need for bedwatch staff. It allows prisoners to stay in an environment they feel comfortable with and where they may choose to die.

108. Dr A is of the opinion that the care the man was given was generally comparable to that which would have been delivered in the community, although he highlights the 'administrative delays' which prevented the man from accessing treatment. Although I cannot be sure to what extent the man's health was affected by the failures to escort him to appointments, I am very pleased that improvements have been made in this regard in the last 18 months. In particular, Ms E has recognised that patients diagnosed with cancer should, without fail, attend all planned hospital visits. I urge both the Governor and the Head of Healthcare to keep a close eye on what is happening in practice.

Response to the deterioration in the man's health on 29 November

109. A post mortem report was not completed because the man's death was expected and his illness had been previously diagnosed. Dr F confirmed the cause of death and made some notes having consulted with his colleague Dr

C (Head of Service, Oncology Department, Nottingham University Hospitals NHS Trust).

110. Dr F and Dr C agreed that the man had died of neutropenic sepsis. As I have said, this is a recognised complication which can occur after a patient has undergone chemotherapy. The man had been undergoing chemotherapy treatment to slow the spread of his cancer. He had last received this treatment the day before he was taken to hospital, 28 November. The healthcare staff at the prison had noticed him becoming visibly more unwell in the last ten days of his life.

111. In his notes, Dr F wrote that he had discussed the case with Dr C. They agreed that the necessary antibiotics had been appropriately administered when the man was brought into the local hospital on the evening of 29 November. Dr C asked Dr F to make a note for the benefit of the Coroner, querying a possible delay in bringing the man to hospital. My investigator spoke with Dr C on the telephone on 24 April 2009. She confirmed her belief that the man could have been brought into the hospital sooner on 29 November. My investigator asked her to explain her concerns.

112. Dr C said that a patient in the community who had recently received chemotherapy and then developed the symptoms of an infection (such as a fever) is instructed to contact their hospital immediately. She would advise a patient to come to the hospital on the assumption that neutropenic sepsis was the likely cause of the fever.

113. According to Dr C, a patient would need to go to hospital for immediate treatment with antibiotics, being brought in by car or ambulance. She would expect the ambulance to be prioritised as an emergency '999' call out. Dr C said that it is 'not that common these days' for a patient such as the man to die as a result of this condition. She told my investigator that 'minutes count', and that the vast majority of cases can be successfully treated if the correct antibiotics are administered within about an hour. She recognised that it was more problematic for a prisoner to be given the antibiotics within the critical timeframe for successful treatment if they developed neutropenic sepsis, given the delays that can be incurred when transferring them from the prison to the hospital.

114. In the man's case, Dr C thought that 'hours had been wasted' before he reached the hospital. She believed that an emergency ambulance should have been called, and the man should have travelled to hospital 'under a blue light'. She considered that there had been an unreasonable delay in his treatment, and that he may have died 'unnecessarily' of neutropenic sepsis. Essentially, Dr C thought that, whilst the man would have died soon afterwards as a result of cancer, his death was brought forward by an infection that could have been prevented if dealt with more rapidly.

115. Dr C's opinion is clearly of concern. Healthcare staff at Whatton had established a routine when the man was receiving ongoing chemotherapy which ensured that his blood was tested regularly and his body temperature

monitored every day. A note was made in the man's medical record to indicate that, if his temperature rose above 38 degrees Celsius, the hospital was to be contacted.

116. When my investigator interviewed Dr D and Ms E, both expressed the view that the man had been expected to live for a few more weeks, perhaps until Christmas 2008. Special equipment had been ordered to arrive on Monday 1 December to help him in the last weeks of his life. There is no indication from the man's medical records that, when Dr D visited him on Friday 28 November, she identified symptoms of neutropenic sepsis.

117. The delay in transferring the man to hospital on Saturday 29 November seems to have been the result of a number of factors. I have considered the actions of Nurse A who was on duty at Whatton over the weekend. She knew that the man had received chemotherapy treatment the day before which could render him more vulnerable to infection. She was aware that his temperature should be checked daily, and that if raised she should report it to a doctor immediately. She did not test his blood because this was not something that was expected of her during day-to-day monitoring of the patient. It was her role to note any changes in the patient's condition, and to report them to a doctor.

118. Nurse A visited the man during her morning rounds. However, he was in the middle of his weekly visit with his wife which she did not want to interrupt. She therefore delayed checking his temperature and completing her assessment until after lunch. She observed that he looked more unwell, and her concern was growing. It is possible that, had she performed a full examination in the morning, she might have been alerted to the need to call a doctor rather sooner than she was.

119. Having assessed the man after lunch, Nurse A decided to telephone the out of hours Nottingham Emergency Medical Services (NEMS) about an hour later, between 2.30pm and 3.00pm. I am concerned that approximately an hour had passed between Nurse A visiting the man in his cell and then making this telephone call. I note that Dr C has said that 'minutes count' when a patient receiving chemotherapy begins to show signs of an infection.

120. Dr E, who was employed by NEMS over the weekend, called Nurse A back after she left a message. She informed him of the man's symptoms, and he consulted with the Oncology Department at the local hospital. He then called Nurse A back and told her that the man was to be admitted to hospital, and that an ambulance had been arranged. Another hour or so had passed, and it was 3.41pm when the ambulance was called.

121. I am concerned that Dr E arranged for an ambulance to pick up the man 'within an hour' and did not request an emergency ambulance. Dr C believes that this should have been done, given the critical timeframe involved in treating neutropenic sepsis. Nurse A did not recall discussing neutropenic sepsis specifically with Dr E. I presume that Dr E decided to call a non-emergency ambulance after obtaining the man's symptoms from Nurse A and

consulting with staff at the Oncology Department. He would have been aware that the man was receiving chemotherapy.

122. I have some reservations about the communication between the three parties involved (Nurse A, Dr E and the Oncology Department at the local hospital) and the advice which seems to have been passed between them.

123. Calls to the ambulance service are treated in one of three ways. There are critical emergencies, call outs that require relatively urgent attention, and then there is the collection of patients where time is not considered to be a critical factor. The call out in the man's case was of the least urgent, latter kind. This meant that an ambulance crew would attend in due course, but it was not considered to be a critical emergency, and other higher priority calls might take precedence if the paramedics were needed elsewhere. Such a call out would be expected to be completed within about 90 minutes, according to the East Midlands Ambulance Service (EMAS).

124. The EMAS policy with regard to neutropenic sepsis states that this is not a condition that automatically triggers the need for an emergency ambulance if the doctor making the call does not think this is necessary. The priority given to the ambulance call out rests with the doctor who has assessed the patient. There are some conditions that oblige the ambulance service to override a doctor's decision, such as meningitis. Neutropenic sepsis is not included amongst these in the current policy. The doctor arranging for an ambulance would be asked if the patient's condition is immediately life threatening. If so, then an emergency ambulance is sent. The ambulance service was not therefore at fault in providing the non-emergency ambulance requested by Dr E.

125. However, although Dr E asked for an ambulance to collect the man within an hour, the paramedics did not arrive for 90 minutes. (The ambulance was ordered at 3.41pm, arrived at 5.07pm, left Whatton at 5.44pm and arrived at the hospital at 6.45pm.) Although the Prisoner Escort Record (PER) shows slightly differing times, it also confirms that the ambulance arrived at the hospital three hours after it was requested. The EMAS log indicates that the reason the paramedics took so long to reach the prison was because there was 'no vehicle [ambulance] available'.

126. It would appear that the man was taken to the local hospital because this was where he had been receiving his chemotherapy treatment. Whatton and the local hospital are on opposite sides of Nottingham, 14 miles apart. The considerable distance between the prison and the hospital clearly lengthened the journey involved, and this is something which I have raised during previous investigations.

127. In total, five hours had passed from the time Nurse A became actively concerned about the man (approximately 1.30pm) and the time he reached the local hospital (6.45pm). I agree with Dr C's assessment that 'hours were wasted'. There appears to have been a failure to understand the urgency involved when a patient who develops an infection has recently had

chemotherapy. When the man was taken to hospital, Governor A (the duty governor that weekend) said that he had 'no idea how serious his condition was'. Nurse A does not appear to have been told by Dr E that the infection could be serious. There seems to have been a lack of understanding that it could be successfully treated if dealt with rapidly.

128. In light of Dr C's comment that 'minutes count' when a patient has developed neutropenic sepsis, I consider that there was an unreasonable delay in ensuring that the man received the treatment he needed, and which might have prolonged his life, albeit briefly. Criticisms could be levelled at Nurse A (who did not complete her assessment of the man until the early afternoon and did not telephone NEMS immediately), Dr E (who decided not to request an emergency ambulance), the member of staff spoken to at the Oncology Department (who may not have emphasised the urgency involved in treating neutropenic sepsis), or the ambulance service (who appear to have had insufficient resources available to ensure that paramedics reached the prison within an hour). However, it is not my intention to apportion blame.

129. I have considered the possibility of storing the antibiotics required to treat neutropenic sepsis in prison healthcare centres to ensure that treatment is delivered as swiftly as possible. This raises a variety of concerns. A member of healthcare staff should ideally not be working alone when they administer the antibiotics. It would not be practical for them to carry out and monitor the procedure when they may have other ill prisoners to care for in the meantime.

130. The necessary antibiotics have to be injected intravenously. Although they can be given to patients by specially trained nurses, they have to be prescribed by doctors (who are often not present in prisons, as was the case at Whatton on Saturday 29 November). Dr C did advise my investigator that nurses can sometimes be trained up to oversee the giving of antibiotics in specific circumstances.

131. However, whether nurses would feel comfortable delivering critical antibiotics without supervision is debatable. Whilst I make no recommendation, I am sure that the Head of Healthcare will want to give careful consideration to the feasibility of keeping the necessary antibiotics to treat neutropenic sepsis in the healthcare centre.

The use of restraints

132. The Local Security Strategy in operation at Whatton at the time the man died (effective from August 2007) instructed staff that restraints should be applied to all prisoners at hospital at all times, other than in an emergency. If restraints had to be removed, the duty governor was to be consulted at the earliest opportunity.

133. The man was still cuffed to Officer B by an escort chain until about an hour before he died. In interview, Governor A (the duty governor on the weekend the man died) accepted that, to provide the man with a dignified death, the escort chain should ideally have been removed sooner than it was. He

emphasised that this opinion was expressed with the benefit of hindsight. He agreed that there had been a lack of emphasis on 'common sense decision making'.

134. Dr D said that she 'really did not like' the fact that the man had still been cuffed at such a late stage. Both members of staff, one speaking from a Prison Service perspective, the other from a healthcare background, highlighted the risks which have to be considered when prisoners are taken to hospital.

135. A combination of circumstances seems to have led to the man being cuffed until very shortly before he died. In particular, his death was not considered to be imminent by healthcare staff at the prison. There seems to have been a consensus that he might be expected to live for several more weeks.

136. What took place on 29 November was a critical situation (the development of neutropenic sepsis following chemotherapy) in the context of a longer, chronic condition (lung cancer). Whilst the man had been a palliative care patient for quite some months, Dr D confirmed that, until a week or two before his death, he had been managing quite well. Over the course of the 20 months he had been diagnosed with cancer, there were long periods when his condition was relatively stable and he coped with the demands of daily life. He had become more and more frail, but there had not been any sudden or critical episodes until this point.

137. The chemotherapy the man underwent weakened him considerably, and it was only in the last ten days or so that his condition markedly deteriorated. The rapid deterioration in his health on 29 November was not anticipated. As I have already discussed, the development of neutropenic sepsis does not appear to have been treated with sufficient urgency by either Nurse A, Dr E, or the paramedics. It seems that prison staff were therefore unaware that his death might occur within a matter of hours.

138. The man was taken to hospital late on a Saturday afternoon. The prison is not fully staffed on a weekend and only one member of the healthcare team was on site. Had the man become very unwell on a weekday, then a member of the management team may well have gone to the hospital later in the day, made a risk assessment, and authorised the removal of the chain.

139. Governor A indicated that he would have visited the hospital on Sunday 30 November to assess whether the man should continue to be cuffed. The Local Security Strategy in place at the time indicated that a manager should visit the prisoner and escorting officers on bedwatch within 24 hours of the departure from prison.

140. When he spoke with my investigator, Governor A said that he had not expected the man to deteriorate so quickly. He had felt that he could wait until the following morning to visit and obtain a prognosis from the doctors. Ms E also indicated that the duty governor would, in all likelihood, have visited

the hospital on 30 November to complete a risk assessment. She felt that they would probably have decided to remove the restraints from the man.

141. Finally, and most importantly, all parties involved seem to have struggled to communicate after the man left Whatton late in the afternoon on 29 November. Hospital staff do not appear to have advised the escorting officers (Senior Officer V and Officer B overnight from 7.00pm) that the man's death was imminent until perhaps an hour and a half before he actually died. Shortly afterwards, the hospital staff requested that the escort chain be removed. Given the imminence of death, Officer B removed the chain to preserve the man's dignity. He then telephoned Senior Officer T at the prison and updated her.

142. Senior Officer V told my investigator that she and Officer B had noticed that the man had become very quiet and seemed to be unconscious from 3.00am onwards. Officer B confirmed much the same thing. He said that it had crossed his mind that the man might be dying, but he did not share this with Senior Officer V.

143. Officer B said that he had not wanted to intrude on the nurses whilst they were doing their job. He waited for them to brief him fully, but that this had not occurred until after 5.00am. Neither officer seems to have been told that neutropenic sepsis could result in the man's death in a matter of hours. From the discussions my investigator had with both officers, it does seem that nursing staff were very busy during the night.

144. Neither Governor A nor Senior Officer T (the night orderly officer responsible for the running of the prison) appear to have tried to establish the man's prognosis. Once the man left Whatton in the ambulance, Governor A went home, and did not speak with the prison or the hospital until after the man had died. Whilst Senior Officer T was in regular contact with the escorting officers, they do not seem to have discussed how ill the man was or whether the use of restraints could be ended.

145. The combination of the unexpected and rapid decline in the man's health, the admission to hospital over a weekend and the failure by all parties involved to understand and communicate the imminence of death led to the man being handcuffed until 5.45am. He died at 6.45am.

146. I make a recommendation which may help to ensure that, in future, staff have the information available to them to ensure that a sensible, humane and well reasoned decision is made with regards to cuffing when a prisoner is so close to death.

The Governor should ensure that, when a prisoner is admitted to hospital unexpectedly, escorting officers at the hospital speak with nursing staff regularly in order to obtain up-to-date information about the prisoner's condition.

147. A preoccupation with the risk to the public from sex offenders may have impinged on the use of discretion and 'common sense decision making' in this instance. From the interviews my investigator conducted, it was apparent that consideration of possible media interest if a prisoner committed a further offence whilst at hospital had the potential to influence the cuffing of prisoners like the man.

148. Whilst risk assessment should be thorough, and public protection is a fundamental priority for the Prison Service, a balance should have been struck between the risk that the man presented as an able bodied younger man and the risk that he presented as a much older man in the final stages of a terminal illness. There seems to have been a lack of finesse and discretion exercised with regard to the man's risk assessment and cuffing during the weekend of 29 and 30 November. Staff seem to have operated under a generalised assumption – namely that all sex offenders represent a risk all of the time. I am bound to say that only a highly risk averse culture could lead anyone to suppose that a terminally ill man of 72, convicted of offences committed more than three decades earlier, represented either a credible escape risk or any risk to public safety. He was using oxygen to assist his breathing and, by the time he was escorted to hospital, was wheelchair-bound. Governor A accepted in interview that the man would not, in all likelihood, have posed a risk directly to the general public.

149. As I have said, it seems that the prison management team may have had some concern about the man assaulting female nursing staff at the hospital. This was of course a perfectly proper concern. However, I note that Dr D and Nurse B had spent a great deal of time in the man's presence in the months before he died. To the best of my knowledge, neither complained of any inappropriate behaviour on his part. Furthermore, there is no evidence to suggest that the man represented a risk to adult women.

150. Governor A told my investigator that escorting and cuffing prisoners is partly for their own benefit. As Whatton is known to accommodate sex offenders, there is a concern that, if a prisoner is identified whilst at hospital, a member of the public may attack them. Whilst the presence of two escorting officers is both a necessary and wise precaution, I struggle to comprehend why the man had to be physically restrained, given the frailty of his health.

151. Whilst I make no further recommendation, I make the broader observation that a necessary focus on sexual offending and an acute awareness of media interest would seem in this instance to have led to an automatic assumption of risk at the expense of a 'common sense' approach.

152. Although staff indicated that they were following the Local Security Strategy guidelines with regard to the use of restraints, many of the deaths I have previously investigated at prisons across England and Wales have provided examples of Governors using their discretion when prisoners are dying.

153. I made recommendations in relation to the cuffing of older prisoners during two previous investigations at Whatton. With regard to the death of a prisoner

in August 2007, I wrote in June 2008 that a full risk assessment, including an assessment of the use of restraints should be prepared by staff and considered by the duty governor when a prisoner who is in hospital experiences a significant change in circumstances. I repeated my recommendation in February 2009 (writing about the death of a prisoner in July 2008), adding that the assessment of the use of restraints should be reviewed every 24 hours.

154. I am pleased to report that Whatton's Local Security Strategy has now been revised, and new quidance has been put in place for staff. My investigator has spoken with Governor A, who has implemented these changes. He emphasised that staff are now encouraged to consider a prisoner's age, mobility and health when assessing the risk they might realistically represent to members of the public. A new and more comprehensive risk assessment form was introduced in spring 2009.

Parole Board decisions

155. The man had been refused parole twice, in January and November 2008. The basis for the Parole Board's decision seems largely to have been his unwillingness to address his offending behaviour (he did not wish to attend an offending behaviour programme) and his continued minimisation of guilt. The Parole Board felt that there was no evidence of a reduction in the risk which the man represented. The decisions of the Parole Board are not matters within my terms of reference, but a refusal to grant release on licence on these grounds seems both defensible and understandable. (This is something that the man's wife asked about.)

Visits

156. When my former Senior Family Liaison Officer spoke with the man's wife, one of her concerns was the lack of privacy which she was able to enjoy with her husband until she was allowed to visit him in his cell on 29 November (the day he went into hospital). On Friday 28 November, Dr D and Governor A had agreed that the man's wife could start visiting her husband in his cell.

157. Permitting family members to visit prisoners in their cells is a relatively new and unusual development. Dr D said that this was something that never used to happen. Very few prisons permit visits to take place in a cell. Staff at Whatton are pioneering this initiative (which I commend), and it is not the only innovation they have implemented in the last 18 months in relation to prisoners with a terminal illness.

158. The new policy allows the family member a degree of privacy when they visit the wing. The cell door is kept open, but a privacy curtain is drawn across the entrance. A mesh observation strip forms part of the curtain, allowing the officer on duty to maintain security. A 'dignity line' is also in place during visits on the wing, indicating to other prisoners that they should not go near the cell.

159. The visits room is a considerable distance from the wing where the man lived, and the distance can be prohibitive for chronically ill prisoners. Governor A told my investigator that it was preferable for prisoners to continue to receive visits in the purpose-built visits room (which is accessible for wheelchair users) for as long as is practicable. If the man was unable to go to the centre on foot, he was pushed in a wheelchair by another prisoner.

160. Whilst visits on wings have been devised specifically in response to the number of prisoners with palliative care needs, the implementation of this policy would only come at a point when the prisoner was so unwell that they were unable to make the journey from the wing to the visits room. There is an understandable need to withhold wing visits until absolutely necessary, as they involve maintaining the safety of the visiting relative and an officer monitoring the visit.

161. On a practical level, very few cells have been equipped with the privacy curtain and such like. Additionally, there is a certain stigma attached to these cells, as prisoners are aware that moving into one means that they are considered by healthcare staff to be dying. The man exhibited a certain reluctance whilst he settled into his cell.

162. In the man's case, as I have already outlined, the decline in his health was rapid and unexpected. Whilst he had a terminal illness, his death was not anticipated for some weeks to come. Hence, when Dr D and Governor A organised the wing visits, they both felt that several more might take place before the man died.

163. When Dr D decided that the man was so unwell that the time was right for his wife to start visiting him on the wing, Governor A authorised it immediately. Prior to 28 November, she had not taken this step as the man was not bed-bound. As a consequence, the man's wife was able to visit her husband on the wing for the first time the next day.

164. My investigator has spoken with two of the prisoners who acted as helpers for the man when he became unwell. (This scheme is another innovation that the management team has implemented to address the growing number of ill and frail prisoners held at Whatton.) Both prisoners said that the man had been pleased with his life on the wing, and was grateful for the help they offered with simple tasks like pulling up his blind and collecting his food. They would push the man in his wheelchair across to the visits room when his wife arrived. Both prisoners were impressed with the prison staff's treatment of the man, saying that all concerned had 'gone the extra mile'.

165. Nurse B told my investigator that the man had always managed to get to the visits room until his final few days. She remembered him being pushed across in his wheelchair, and she could not recall him ever complaining about this arrangement. Governor A said that the man had been 'happy' to make his way to the visits room to see his wife. He too could not recall the man's wife complaining to him about the visiting arrangements which had been put in place.

The possibility of the man being released

166. As noted, the man made two applications to the Parole Board. He wanted to return to live with his wife. Both applications were refused on the grounds of the risk he represented to the public. Healthcare staff submitted an account of the man's diagnosis and frailty but it would appear that these concerns were outweighed by public protection issues.

167. Similar concerns affect requests for the early release of prisoners on compassionate grounds. The offences committed by prisoners at Whatton mean that this is a rare occurrence. Governor A told my investigator that, in the 14 years he has worked at Whatton, he could only remember one prisoner who was released early on compassionate grounds into the care of his family, five days before he died. (Such decisions have to be approved by the Secretary of State for Justice.)

168. Ms E said that the threshold for prisoners granted release on compassionate grounds was 'quite high' as a result of the nature of their offending and the risk they were considered to present to the public.

169. Ms C, the Secretariat Manager, confirmed to my investigator that the man did not request early release from prison on compassionate grounds. Nurse B said that the man had expressed his satisfaction with the treatment he was receiving at Whatton. She said that he had not complained about the care he was receiving, and had in fact praised the staff.

170. Dr D and Ms E spoke about their intention to care for terminally ill prisoners. They hope that prisoners with palliative care needs will be able to remain at Whatton until their death, if that is what they prefer. This is an admirable goal, reflecting the fact that, as I have written elsewhere, the Prison Service has become in effect a welfare agency as well as a criminal justice one.

CONCLUSION

171. My investigation has raised some serious concerns about the care the man received. Indeed, the delay in treating the infection which caused his death may raise questions about how appropriate it might sometimes be to give chemotherapy to prisoners. Given that the man was in the final stages of a terminal illness, and that chemotherapy can have potentially fatal complications which have the potential to shorten life rather than extend it, Dr C thinks that this is something which may require closer consideration. Whatton lacks inpatient treatment facilities and 24 hour healthcare, and is geographically distant from the hospital, meaning that prisoners are less likely than a member of the public to be able to access promptly the necessary antibiotics. I make no recommendation but draw Dr C's observation to the attention of Offender Health.

172. Nonetheless, progress has clearly been made at Whatton with regard to the treatment of terminally ill prisoners. Palliative care has become a priority for the healthcare team. I am pleased that the recommendation I made with regard to the death of a prisoner in June 2007 and the need for a palliative care strategy seems to have been implemented. Dr D, Ms E and Nurse B all spoke with pride about the service they are either currently delivering to their patients or which they are aspiring to deliver.

173. In spite of the criticisms in this report, my investigator has found grounds to be optimistic about the treatment that elderly prisoners are receiving at Whatton. Prisoners are being consulted and offered some choices about the way they are looked after. I consider that the healthcare staff (with the support of both Governor Saunders and the local branch of the Prison Officers' Association) are pioneering several innovations that are changing the treatment of older prisoners who face the prospect of ending their life in Whatton. I commend the improvements being made, but equally hope that some lessons can be learnt from this investigation into the death of the man.

RECOMMENDATION

1. The Governor should ensure that, when a prisoner is admitted to hospital unexpectedly, escorting officers at the hospital speak with nursing staff regularly in order to obtain up-to-date information about the prisoner's condition.

   NOMS partially accepted the recommendation and gave the following response:

   'Escort staff are already expected to liaise with the hospital staff about the prisoners condition, however depending what nursing staff are on duty will depend on what information is shared. This information is then recorded in the bedwatch occurrence log. Managers visiting the bedwatch each day are expected to consult with the healthcare staff and pass any information back to the Head of Security so that any change of risk can be reflected in the prisoners risk assessment.'