Investigation into the death of a man in October 2010, at Royal Preston Hospital, whilst released on temporary licence from HMP Wymott

Report by the Prisons and Probation Ombudsman for England and Wales

August 2011

This is a report into the death of a man in October 2010, at the Royal Preston Hospital, whilst he was in the custody of HMP Wymott. The post mortem showed that he died from cancer.

I offer my sincere condolences to the man's family and friends for their loss. One of my Family Liaison Officers contacted the man's father to discuss the investigation and give him with the opportunity to raise any issues about the care his son received in custody. After this initial contact, one of my senior family liaison officer, liaised with the man's father.

The investigation was carried out by two of my investigators. Both they and I would like to thank the Governor of HMP Wymott and his staff, for their co-operation during the course of our enquiries.

Central Lancashire Primary Care Trust were commissioned to conduct a clinical review into the care the man received while in custody. They appointed the clinical reviewer to undertake the review, and I am grateful for her contribution to this investigation, which is the first annex to this report.

My investigation, and the conclusion of the clinical reviewer, is that the standard of care which the man received was below that which he could have expected in the community. I think that a more expedient referral for specialist orthopaedic assessment should have been made when the man's symptoms of pain and discomfort persisted and increased. Furthermore, greater scrutiny of the medical records, in conjunction with the comments from uniform staff about his increasing difficulties, should have identified the need for a referral to a specialist at an earlier stage. Whilst I do not think that earlier intervention would have prevented his death, I judge that the pain which he endured could have been better managed.

I make eight recommendations, which address the consistency of GP provision within Preston and Wymott prisons, appropriate and timely referral for specialist diagnosis, communication between uniform and healthcare staff and record keeping.

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

Nigel Newcomen
Deputy Prisons and Probation Ombudsman **August 2011**

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SUMMARY

1. The man was convicted of drug offences and sentenced to a two year term of imprisonment by Lancaster Crown Court in March 2010. He was taken to HMP Preston and underwent an initial health screening (a process to identify immediate health needs and to obtain a medical history). He disclosed a history of drug use and that he was taking methadone (methadone is widely used as a substitute for those wanting to combat heroin addiction). The man said that he smoked, but had no other significant medical issues.

2. In April, the man reported that he had slipped getting down from his bed and sustained an injury to his shoulder. He was assessed by a prison doctor on a number of occasions whilst he was at Preston as the pain did not reduce. He was prescribed pain killers and anti-inflammatory medication and diagnosed with a musculo-skeletal injury. The man reported increasing pain discomfort to healthcare staff. He was examined by a prison doctor at Preston at least five times. It was likely that he was seen on more occasions, because he was prescribed pain relief medication, although this was not recorded in his clinical record. Wing staff noticed that he was experiencing pain and they made referrals to the healthcare centre on his behalf. However, no further investigations were made into the cause of his pain and discomfort.

3. He was transferred to HMP Wymott in August, and on his arrival another health screen was completed. He again mentioned the significant pain in his shoulder. His medication was reviewed and he was prescribed more painkillers for what was thought to be a musculo-skeletal injury. During the next few weeks, he was unable to go to work due to the pain he was experiencing and received help from other prisoners and prison officers to collect his meals and clean his cell.

4. A prison doctor examined him four times during August. This included a referral from gymnasium staff who thought the man had dislocated his shoulder. On 2 September, the prison doctor asked for blood tests and made an urgent referral for the man to have an orthopaedic assessment. There is no evidence that the blood tests were ever completed. On 4 October, he was examined by a nurse, who observed that he had lost a significant amount of weight, was in pain and had clubbing of the fingers (a deformity of the fingers and fingernails that is associated with a number of diseases, mostly of the heart and lungs).

5. On 13 October, the man was escorted to Chorley Hospital for an orthopaedic appointment. Following an x-ray, he was immediately referred to the accident & emergency department as a large malignant mass was found in his lung. The man was advised that he had cancer and was transferred to the Royal Preston Hospital as an inpatient to begin immediate treatment. All restraints were removed on 16 October and he was released from custody on temporary licence from 20 October.

6. I make eight recommendations a result of this investigation which relate to the consistency of GP provision within Preston and Wymott, appropriate and timely referral for specialist diagnosis, communication between uniform and healthcare staff and record keeping.

THE INVESTIGATION PROCESS

7. The investigation was opened on 4 November 2010 when my Assistant Ombudsman and investigator visited HMP Wymott. Notices were issued announcing the investigation to staff and prisoners. One officer came forward as a result. During this initial visit, the investigators were given copies of the man's core prison record, clinical record, and other records relevant to his time in custody and his death. My investigators met the deputy governor, a member of the Independent Monitoring Board (IMB) and the prison family liaison officer.

8. My investigator returned to Wymott on 5 January 2011, interviewed one prisoner (who declined to have the interview recorded), visited D wing (where the man lived) and the healthcare centre. My investigator observed that there were a number of clearly identifiable information boards, including those for IMB, Samaritans, healthcare, chaplaincy, and the Prisons and Probation Ombudsman. There was a board directly outside the man's cell explaining how to make an informal/formal complaint to healthcare or the PCT, regarding any issues relating to healthcare provision. The following week my investigator interviewed two agency prison doctors, at Preston, on 12 January. A third agency doctor was invited for interview but did not respond to the request to provide further contact details. Both my investigators returned to Wymott on 13 January, when they interviewed five members of staff. In addition, one member of staff at Preston was later contacted by telephone at the request of the family. Initial feedback from the investigation was provided, in writing, to both the Governors of Preston and Wymott, on 1 February.

9. Central Lancashire Primary Care Trust asked a clinical reviewer to review the man's clinical care and she was provided with all relevant documentation to assist this review. The investigators and the clinical reviewer discussed aspects of the man's treatment, and jointly conducted all the interviews with prison and healthcare staff at Wymott and Preston. I am grateful to the clinical reviewer for her contribution to the investigation and for her report.

10. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

11. A member of my family liaison team contacted the man's father to explain the investigation process and invite him to ask questions or raise concerns about his time in prison. The man's parents and sister raised a number of concerns during telephone conversations with my family liaison officer and requested a meeting. The family liaison role was later taken over by another of my family liaison officers and both she and my investigator met with the family in January 2011. During this meeting, the family discussed their concerns which I have considered during the investigation. The man's family asked:

- Where was the duty of care given to the man by the Governors and Prison Service? The family do not believe that the man was shown the care which he and they expected. The man's family referred to the Prison Service statement that "all prisoners will be treated with humanity" which is the responsibility of the Governing Governor and his staff. However, they believe that the man was allowed to remain in a significant amount of pain.

- Why was the quality of care provided by healthcare in Preston and Wymott not comparable to that which he would have expected to receive in the community? The family do not believe that the man was afforded equitable provision and they say that he was denied appropriate pain relief by healthcare staff.

- Did the man's previous history of drug misuse lead to assumptions about his truthfulness and was this the reason why he did not receive appropriate care?

- What were the actions available to the man to access or complain about his treatment?

I hope that my report offers insight into the man's time in custody and to their questions.

The man

12. The man was born in Halifax, West Yorkshire. He lived in Lancashire, where he moved in 2002 to be close to his sister with whom he had a very strong and supportive relationship. He was not employed, having been made redundant from a factory job in 2004, when the business closed down. He had a history of substance misuse dating back to the 1990s, and a number of previous convictions that were directly linked to his substance misuse. However, he had not been in prison before. The man was single and had no children.

13. The man appeared at Lancaster Crown Court in March 2010, when he was sentenced to two years in prison for supplying a class A drug. Initially the man was taken to HMP Preston, transferring to HMP Wymott on 6 August 2010. He cooperated with the CARATs team, demonstrating a renewed motivation and complying with his methadone care plan. (Counselling, Assessment, Referral, Advice & Throughcare Service - there are drug workers based in most prisons from organisations specialising in the treatment of substance abuse. CARATs workers can run programmes, and offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary.) He successfully completed a methadone detoxification on 17 August. He also used the education facilities at Preston to improve his literacy and numeracy skills.

14. Following his death, a collection was made by his peers at both Preston and Wymott which demonstrated the level of regard in which he was held. The collection was described by a Governor at Wymott as "quite rare". Staff during interview reflected that he fully complied with the prison regime, posed no problems for staff, was well liked and his death was described as a sad loss.

HMP PRESTON

15. Preston is a large Victorian prison, situated near the town centre. It operates as a category B male local Prison, serving the courts of Lancashire, holding male offenders aged over 21 years who have been remanded in custody, are awaiting trial, or allocation to another prison after sentencing.

HM Inspectorate of Prisons (HMIP)

16. Preston was last inspected by HM Chief Inspector of Prisons (HMIP) in April 2009. The Chief Inspector commented that:

> "HMP Preston is an overcrowded, largely Victorian, inner city local prison with a transient population of needy and sometimes challenging prisoners. Yet despite these constraints and demands, this announced full inspection found the prison to be performing reasonably well against all our tests of a healthy prison."

17. In relation to healthcare, inspectors found that:

> "Once an application form had been received, there was a six or seven day wait for an appointment with the GP or nurse prescriber. Prisoners complained to us about the length of the waiting list to see the GP, and told us that they often submitted multiple applications for this reason. One of the administrative staff identified whether the prisoner should be seen by a nurse or a doctor, based on the information supplied on the application form. Prisoners were sent an appointment card one to two days before their appointment. The clinicians were given the application forms before the clinic, so they knew how long prisoners had waited to see them. However, the GP seemed unperturbed that one of his patients had waited over three weeks to see him. Not all prisoners due to see a clinician attended; this was made worse if there was not a 'runner' from the healthcare department to escort them to or from the department."

Independent Monitoring Board report (IMB)

18. Each prison has an Independent Monitoring Board (IMB), whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record. The man had no contact with the IMB

19. In their annual report for the period April 2009 to March 2010, the Independent Monitoring Board made the following comments:

“The staff at HMP Preston are showing commendable ambition for the future (in spite of horrendous imposed cuts to an already impoverished budget), which the Board shares, whilst hoping that the conditions for all concerned will be improved to enable that ambition to be fulfilled. Specifically, we repeat what was said in the executive summary of this report: ‘Preston is a commendable prison in which prisoners are cared for humanely and decently, and in which many staff are ready to go that extra mile on prisoners’ behalf.’.

“Healthcare has recovered from the unfortunate difficulties of last year much to everyone’s relief. With a wide variety of multi-disciplinary staff ranging from GPs, psychiatrists, substance misuse specialist GPs, counsellors, opticians and podiatrists to Registered General and Mental Health Nurses, Health Care Officers and support workers, NHS Central Lancashire is meeting the physical and mental health needs of the prison population working in partnership with the prison and outside agencies.”

Previous deaths in custody at Preston

20. There have been 12 previous deaths at Preston since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004. Preston is a regional inpatient healthcare resource for the Prison Service. I have previously made recommendations regarding the recording of clinical contacts by all staff, continuity of clinical care and staff training.

HMP WYMOTT

21. HMP Wymott is a large category C prison which holds sentenced prisoners. Wymott accommodates both vulnerable prisoners (those who might be subject to being bullied by other prisoners, often due to the nature of their offence) and prisoners on ordinary location.

22. Mainstream prisoners and vulnerable prisoners are held in separate accommodation and so Wymott is effectively two separate prisons with their own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Wymott can hold a maximum number of 1,062.

23. Healthcare services at Wymott are commissioned and provided by Central Lancashire Primary Care Trust. There are no inpatient beds, so prisoners often go to Preston, which has an inpatients' unit.

HM Inspectorate of Prisons' report

24. Wymott was last inspected by HM Chief Inspector of Prisons in October 2008. The Chief Inspector commented that:

> "Wymott is a large category C training prison, holding over a thousand men. It has expanded 25% since its last inspection in 2003. Unlike many training prisons which have undergone similar expansion, Wymott has managed to sustain its performance and the quality and quantity of activity available to its prisoners."

25. In relation to healthcare, inspectors commented:

> "Health services were commissioned and provided by Central Lancashire Primary Care Trust (PCT), which also commissioned health services for HMPs Garth and Preston. A health needs assessment and health delivery plan had been completed. A partnership board, which met bimonthly, was held jointly for the three prisons.
>
> "The healthcare centre was centrally located. The department was on the first floor, with access by stairs or lift.
>
> "GP services were provided by a private company, and clinics were run every weekday morning and two afternoons each week. Out-of-hours medical cover was provided by the same provider. Although there was no inpatient facility at the prison, there was nursing cover 24 hours a day.

Independent Monitoring Board (IMB) report

26. In their annual report for the period June 2009 to May 2010, the IMB made the following comments:

> “The Board considers that the prison continues to provide a safe environment within which prisoners are treated with decency and respect (both of which have been a focus of management activities during the reporting year) and that prisoners have access to an extensive programme of education and skills. The Senior Management of the prison have set out to address those areas where prisoners are not treated decently within the limitations of what the prison can do given its national resource allocation.
>
> “The Board considers that Healthcare provision at HMP Wymott is satisfactory but there needs to be an improvement in the level of service in order to bring it up to that provided in the wider community. The HMCIP report of 2009 criticised the length of time that prisoners have to wait for a GP appointment. Nurse Practitioner clinics and increased GP time have helped to reduce the waiting list and the Board is pleased to report that currently the waiting time has reduced, but not significantly.
>
> “The contracted GP supplier does not often provide the same GPs from its bank, some of whom may make only a single visit to the prison. This prevents continuity of care, GPs having the opportunity to build up their experience of dealing with prisoners and the prison, and becoming aware of the issues surrounding the prescribing of medicines in a prison environment. The Board is also concerned that the contracted GP supplier has not provided GP cover for a significant number of sessions during the reporting year.
>
> “This prevents GPs having the opportunity to build up their experience of dealing with prisoners and the prison or becoming aware of the issues surrounding the prescribing of medicines in a prison environment. As a consequence it has been considered essential for nurses to be present during consultations. The Board fully understands the reasons for this requirement but believes that this reduces the NHS aim of providing prisoners with a service equal to that to be found in the wider community. The Board brought this issue to the attention of the PCT in its last Annual Report. In the Minister's response to that report it was stated that *'prisoner consent is obtained in these situations'.* Conversations with many prisoners show that this is not the case. Additionally some prisoners have stated to the Board that their treatment was often discontinuous and attributed this to not seeing the same GP more than once. These prisoners also complained of changes in prescribing depending upon which GP was seen and appears to be a common cause of frustration.”

Previous deaths in custody at Wymott

27. This is the 27th death of a prisoner at Wymott since the Ombudsman began investigating all deaths in custody in England and Wales in April 2004. Twenty three of the previous 26 deaths were due to natural causes, while the remainder were self inflicted. Wymott has a high proportion of older offenders. I am satisfied that there are no similarities between the man's death and the other deaths at Wymott.

Performance ratings

28. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. For the last three performance reports, both Preston and Wymott have been given a rating of 3.

Risk assessments

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

Release on temporary licence (ROTL)

30. In certain circumstances, a prisoner may be allowed to leave prison on a temporary licence. The purpose of this is either for compassionate reasons or to help the prisoner improve their chances of resettlement after their release. ROTL is designed to ensure that suitable prisoners are released for precisely defined and specific activities, which cannot be provided in Prison Service establishments. In order to ensure public safety and maintain public confidence in the system, prisoners are only released on temporary licence after they have been rigorously assessed and approved for ROTL by an authorised senior manager.

KEY EVENTS

31. The man was convicted of drug offences and sentenced to two years imprisonment by Lancaster Crown Court in March 2010. He was initially taken to HMP Preston, but transferred to HMP Wymott in August 2010.

32. On his reception at Preston, the man was given a place on D wing, the First Night Centre, where an induction programme took place. During induction, prisoners are provided with information on all aspects of the prison regime. As part of the first night procedures, he was assessed by the first nurse who completed the initial health screen. During the screening, the man said that he had a history of substance misuse and had been prescribed a methadone maintenance programme. He also told the nurse that he suffered from low moods and had been prescribed citalopram, but that he did not consider himself to be at risk of suicide or self-harm. (Citalopram is commonly prescribed to treat depression.) The man also said that he had an inhaler for asthma, but said that he was unsure whether he had actually been diagnosed as asthmatic. He was a smoker, but had no other significant physical medical problems.

33. The next day, 16 March, a second nurse completed a 'Well Man' assessment. (A Well Man assessment involves advice being provided to the patient on healthy living and recording blood pressure (BP) and weight.) The man's weight was recorded as ten stone (63.5kg) and his blood pressure was 127/69. (Normal blood pressure is regarded as being between 90/60 and 120/80.) The man was also referred to the CARATs team.

34. A healthy lifestyle assessment was completed a week later on 23 March, where the man's weight was recorded as 55.8kg, with an 8.3% body fat reading, and his blood pressure noted as 129/71. (This was a significant weight loss in a very short period of time but there is no evidence that this was discussed with him or followed up by healthcare staff.)

35. From the letters which the man wrote to family members, and which have been made available to the investigator, it would appear that he injured his shoulder slipping from his bed in April. In a letter sent to his family dated 1 May, the man told his family that he had begun using the gymnasium again after having chest pain. He said in the letter that he had been told he had most likely "pulled a muscle". He also complained that he had been waiting over two weeks to see a doctor. He said in his letter that a member of healthcare staff had seen him on the wing and reassured him, after being asked to do so an officer. However, there is no entry in the electronic clinical record relating to this. Prescription records show that the man was given paracetamol for "muscular pain" on 19, 20, 21 and 24 April, ibuprofen on 4 May and paracetamol on 13 and 29 May. The medication was given after the man had reported 'special' sick' (special sick is the term used when a prisoner is unable to attend work or education) but, again, there are no corresponding entries on the electronic clinical record.

36. In a letter to his sister on 7 May, the man said that he had finally seen a doctor after waiting three weeks, and had been prescribed naproxen. (Naproxen is commonly used to reduce pain, fever and inflammation.) The prescription records show that naproxen was prescribed for 28 days on 6 May. However, again there is no entry in his clinical record to show that he had been examined.

37. The man was seen by the first agency doctor, on 17 June, as he had complained of ongoing right shoulder pain. He was examined and it is recorded that his chest was clear. There was no evidence of trauma, cough or shortness of breath and no bony tenderness. He was able to move his shoulder by 130 degrees. The doctor diagnosed muscle strain and he prescribed celecoxib and paracetamol (celecoxib is commonly prescribed to relieve pain and inflammation).

38. On 8 July, the man was assessed by the first doctor again. He was still experiencing shoulder pain and was now only able to move his shoulder by 90 degrees. The doctor prescribed nortriptyline, and made a referral for the man to have physiotherapy. The referral was sent to the Royal Preston Hospital a week later on 15 July. (Nortriptyline is used to treat depression and chronic pain.) The doctor assessed the man again on 19 July, due to the ongoing pain he was experiencing in his shoulder, and increased the prescription for nortriptyline.

39. A second doctor, who is also an agency doctor, assessed the man on 30 July. He was still experiencing shoulder pain and the man said that he injured his shoulder when he got off his top bunk bed. The doctor recorded that there was a mild deformity of the lower scapular (shoulder blade) region and wasting of the muscle. Although the man experienced pain, it is recorded that he had full movement and the doctor agreed that he had sustained a shoulder injury. A letter from Central Lancashire NHS was received the same day, confirming that the referral had been received and the man was on the waiting list for the physiotherapy department. There is no evidence that the man ever received an appointment from the physiotherapy department or that the referral was followed up.

40. On 6 August, the man was told that he was to be transferred to Wymott later that day. He wrote to his sister before he left, outlining his frustration at being in pain, his dissatisfaction with the way he had been treated by the prison doctors and the difficulties he had accessing treatment. In the letter, he told his sister “I’m getting worse” and that he had said goodbye to the first officer who had told him she was sorry that she could not help him more. He told his sister that the officer had told him that in her opinion, compared to three months before, he was now “like a crippled old man”.

41. During the investigation, my investigator spoke with the first officer over the telephone. She expressed her shock and sadness that the man had died and described him as a “lost soul”. Recalling him, she said that:

> “The man had problems with his shoulder. He told me that he used to cry with pain at night and couldn't sleep. I called the healthcare to look at him and recorded this in the observation book.”

42. The officer said that, in her opinion, the man “… didn't want to complain, he was not that kind of prisoner, he did not make a fuss, just kept himself to himself”. She also said that he always looked “drained and pale”. She felt that “'things” should have been looked at sooner, although she acknowledged that, as he had slipped on his bunk, it seemed as though there was an explanation for his pain. The officer said that when she called healthcare staff, as she was not medically trained, she had relied on their judgement.

43. All the members of the healthcare team at Wymott had access to the man’s electronic clinical records after he transferred. Following his induction and initial healthcare screening on 6 August, the man’s weight was recorded as 53kg (nearly three kilos less than when it was measured five months earlier) and he told the nurse about the pain in his shoulder. A medical risk assessment report records that he was assessed in regards to his labour classification (an assessment to identify suitable work placements within the prison) and he was deemed to be Labour 2, meaning that he was thought to be able to undertake light duties with some physical work.

44. Five days later, on 11 August, he was examined by a third doctor. He told the doctor that he had sharp nerve pain in his right shoulder and chest. The man said that he incurred the injury when trying to get off his bed some months previously, sustaining torn ligaments in his chest wall. The doctor recorded that the man asked for gabapentin (used for nerve pain) as he had been advised by others that it would help with nerve pain. During interview the doctor said:

> “one of the factors why he might have been denied adequate pain relief was because he was on methadone and if you see you’ve got posters everywhere in the consultation room where it says no Gabapentin, no Tramadol, no opiates when someone is on methadone”

The Prison Service confirmed:

> ‘Gabapentin is not a “banned” medication but is used appropriately with pain referral after using the World health Organisation pain ladder, local protocol reflects this and the locum GP’s were provided with the information within the induction pack’

45. Following a long discussion with the doctor, the man was advised that it was likely that he had a trapped nerve in his back. The nortriptyline was stopped and amitriptyline with diclofenac was prescribed in its place and a further

referral for physiotherapy was made. (Amitriptyline is used to treat both depression and pain associated with the nerves. Diclofenac is used to treat pain and inflammation of the joints.)

46. When my investigator met the man's sister, she said that she had encouraged her brother to ask for gabapentin. She explained that, as a nurse and concerned for her brother's welfare, she was familiar with this medication and thought that it might have provided him with relief from pain.

47. The man was assessed by the third doctor again on 14 August, having been told by a gym officer that he had dislocated his shoulder. Following examination, the doctor concluded that there was no evidence of a dislocation but told the man to come and see him again in a week. The doctor recorded that he planned to refer the man for an x-ray as he kept attending with the same problem. (There is no evidence that this referral was made.)

48. The third doctor assessed the man again only two days later, as the pain in his shoulder continued. As a result, the prescription for amitriptyline and diclofenac was increased. The doctor recorded that he asked the wing staff to monitor the man's movements on the wing to validate his claims that he was having difficulties with his shoulder. He also recorded that the man's condition was to be reviewed in two weeks. When interviewed, the doctor explained that he had asked wing staff to monitor the man's movement, as he had to be mindful that prisoners, including those with a history of drug misuse who ask for specific and banned substances, might try to obtain medication to take themselves or use as currency with other prisoners.

49. The third doctor also told the investigator that the man complained of pain in his shoulder which he said was due to a fall from a bunk bed a couple of months before. The doctor explained that his consultation was concentrated on that problem and providing the man with adequate pain relief. The doctor confirmed that at no point did he suspect anything else to be the cause.

50. During interviews, staff explained the restrictions regarding the prescription of some opiate based medications and pain killers in prison. The doctors reiterated that they need to be vigilant in case prisoners try to obtain medication for illicit purposes. However, they also said that, irrespective of any suspicions, the care and well-being of any patient is a priority and would not influence their judgement.

51. The man continued to have a reducing methadone prescription. It is recorded that, by 18 August, he had successfully completed his detoxification. The third doctor prescribed buscopan (for stomach cramps), loperomide (for digestive problems) and maxolon (to relieve symptoms of nausea and vomiting) for symptomatic relief having stopped his methadone.

52. A third nurse was asked about the correlation between the man's increased pain and the reduction in his methadone. She explained that the methadone would have "masked" the pain because it is a synthetic opiate but, as it was reduced, the man's pain would have become more apparent.

53. A fourth doctor examined the man on 20 August following his successful detoxification. She recorded that the man said he was still experiencing shoulder pain and had not had physiotherapy. The doctor recorded that she thought the man looked anaemic and she asked for blood tests (FBc - full blood count, U+Es – urea & electrolytes and LFT – liver function test). There is no evidence that these blood tests were completed.

54. On 2 September, the second agency doctor recorded that an urgent referral to the orthopaedic clinic at Royal Preston Hospital had been made after the man again complained of continuing pain in his right shoulder. (The only two week rule for referrals is for those considered to have cancer, the GP in this case did not suspect cancer and therefore made an urgent referral which is an appointment within 6 wks). The doctor confirmed his previous diagnosis of a superficial injury of his scapular.

55. The man was reassessed by a fourth nurse on 4 October, so that she could assess his labour grade and capacity to work. She recorded the medication the man was prescribed, and that he was experiencing continued and increasing pain and discomfort in his right arm and upper back. The nurse also noted that the man was short of breath when walking into the examination room, although this resolved after a few minutes with rest. The nurse recorded that the fingers of his right hand appeared to be clubbing (this is a deformity of the fingers and fingernails which is associated with a number of diseases, mostly of the heart and lungs).

56. The fourth nurse's diagnosis was that the man had a musculoskeletal injury. She ordered that he should have four weeks rest in cell and he was referred for in-house spirometry (a pulmonary function test to measure lung capacity). An appointment was made for 20 October. She prescribed food supplement drinks and told him to have his meals collected for him. My investigator spoke to a fellow prisoner who lived in the cell next to the man. He confirmed that he and other prisoners assisted him, and they were encouraged and supported by wing staff in doing so.

57. The fourth nurse recorded that the man was listed for a routine blood test on 11 October, and he was to be reviewed in three weeks time. The man did not go to the clinic on this day but there is no explanation recorded for his failure to attend, or whether this was followed up.

58. On 13 October, the man went to Chorley Hospital for his planned appointment with the orthopaedic department. A risk assessment was completed that authorised a two officer escort and the use of an escort chain which was to be removed for treatment purposes only.

59. The man had a standard x-ray and was seen afterwards by a consultant orthopaedic surgeon, who referred him immediately to the accident and emergency department. The consultant orthopaedic surgeon wrote a follow up that day to the prison doctor at Wymott, in which he said:

"He [the man] was quite clearly very ill today on arrival to the fracture clinic. He had been referred with right shoulder pain following an incident climbing off the top bunk of his bed. Since then he has had shoulder pain, despite this he was able to demonstrate almost full forward flexion (bending of the joint) while he was reclined on the bed. We did x-rays of his shoulder. The x-rays of the shoulder were unremarkable … It was quite clear that he had no passity [this is likely to be a spelling mistake in the original document and should read opacity, which refers to tissue that is not transparent] in the upper part of the right chest, so the radiographers did a chest x-ray and this shows a marked consolidation of the right upper lobe [consolidation is caused by the presence of fluid instead of air in areas of the lung, usually an indicator of an infection, the lobes are the different areas of each lung], this may well represent a low viral pneumonia … As he is rather unwell I have immediately sent round to casualty and they have agreed to see him there. I suspect his right shoulder pain may well be referred pain from whatever pathology [disease] there is in his chest. I have also now been able to see a report on his chest. He has a large mass in the upper half of the right chest extending into the right supraclavicular fossa [collar bone] and right sides of the neck. Appearances of those are advanced pulmonary malignancy [lung cancer], therefore referral to casualty was even more appropriate."

60. The man was admitted to Chorley District Hospital and, following further tests, an aggressive cancer was confirmed. A bed watch consisting of two officers and the continued use of restraint by an escort chain was authorised. (The bed watch consists of two or three daily shifts where officers will stay with a prisoner who has been admitted as an inpatient. However, depending on the circumstances, the bed watch may be withdrawn. A written daily log is maintained throughout and prison manager visits each day to assess the level of restraints.) The following day, £10 was issued to the man to enable him to speak to his family by telephone.

61. On 15 October, the man's family were given permission to visit each day and they were issued with seven visiting orders. (When a prisoner is convicted, if they wish friends or family to visit them, they must send a visiting order which the visitor uses to book a visit. Orders are usually valid for 28 days. The form requires that the names and addresses of all visitors to be given and visitors must bring proof of identification before they are allowed in.)

62. The same day, the man was advised that he required urgent radiotherapy treatment and so he was transferred by ambulance to the Royal Preston Hospital at 6.05pm for this palliative radiotherapy course. (Palliative radiotherapy is designed to relieve symptoms of pain and improve quality of life, it is not a cure for the disease). The first treatment was started at 8.30pm.

63. The next day, a second Governor visited the man in hospital at 2.30pm and, following a review of the risk assessment, all the restraints were removed at 3.00pm. At 3.25pm, the doctor visited the man and his family, explained the planned treatment programme and advised him that his condition was terminal.

64. A consultant clinical oncologist from Royal Preston Hospital, sent a letter to the medical officer at Wymott on 18 October. In the letter, The oncologist said:

> “There are metastases [cancer] in the right and left lung as well as a large destructive mass in the right apex invading and destroying most of the posterior chest wall and ribs … On examination: right-sided Horner’s Syndrome [which is a neurological disorder, resulting from disruption in the nerve fibres running from the brain to the face and the eyes], marked venous distension [a clinical indicator of obstruction to the return of blood to the right atrium] over anterior and posterior chest wall with mass palpable on back. Some paraesthesia [tingling] over posterior chest wall.”

65. The consultant clinical oncologist’s letter concluded the man had been informed that his life expectancy was “a year or two at best”.

66. Over the next few days, the man continued to receive treatment. The bed watch staff recorded that he remained in good spirits despite the pain he was in, and he was talkative and polite at all times. He continued to have support from his family and the Governor arranged for them to be issued with daily visiting orders.

67. An application for the man to be released on temporary licence (ROTL) was considered on 20 October. A special purpose release was granted by the Governor for the duration of the man’s treatment. Following this approval, uniformed bed watch staff were no longer required and they left the hospital in the afternoon of the same day. The man’s family were able to visit him whenever they wished, without the need for a visiting order.

68. Whilst the man had been subject to the bed watch, the prison were regularly updated with information regarding his condition, the Acting Head of Healthcare, along with a Governor had visited the man at the Royal Preston Hospital. However, there is no evidence that there was an established line of communication between the hospital and a nominated prison representative after the man was granted ROTL.

69. At 10.00am in October, eight days after the man was released on temporary licence, Detective Inspector of Lancashire Police, notified the prison that the man had died. A Governor was nominated as the prison’s family liaison officer, at the point of the man’s death. Initially, he tried to speak to the man’s sister who was still at Royal Preston Hospital, but was advised by staff that she did not wish to speak to a prison representative and asked for all future correspondence to be in writing. He wrote a letter to the man’s sister the same day, outlining the role of the family liaison officer, offering assistance in dealing with the various agencies that would be involved such as the PPO and the Coroner, and offering financial assistance towards funeral costs.

70. A post-mortem was carried out on 1 November by a consultant pathologist. He concluded that the man died from bronchopneumonia due to carcinoma of the lung.

71. The man's father contacted the Governor was nominated as the family liaison officer on 1 November. He asked for his son's personal belongings to be returned and arranged for the family to visit Wymott.

72. On 3 November, the man's parents went to Wymott and viewed the wing where he had lived, and the healthcare centre. The family were given his property. Financial assistance for funeral expenses was again offered. The man's father also identified a number of items that may have been missing from the man's property and the Governor assured that he would investigate. These issues were later resolved.

ISSUES

Clinical care

73. When the man arrived at Preston, it seems that, based on the information he provided during the initial health screening, he thought that he was in reasonably good health. It is likely, however, that he already had the cancer that would lead to his death seven months later. The clinical reviewer judges that, whilst it is unlikely that earlier intervention would have prevented his death, the pain that he endured should have been managed better.

74. Following the issue of the draft report and comments from the family regarding the man's life expectancy had he been diagnosed sooner, the clinical reviewer responded:

- It would be very difficult and speculative to say whether treatment would have extended the man's life.
- Not all patients respond to treatment the same and the progression of the disease is different for each individual.
- Earlier intervention could have meant that symptom control and management was achieved as best as possible, which may have improved the quality of the remainder of his life.
- The man's body was weakened greatly due to the extensive disease process that was occurring

75. The reviewer assesses that there was a delay in referring the man or appropriate secondary care. There was no evidence of a multidisciplinary approach and little evidence that the man's clinical notes were reviewed prior to each examination by a prison doctor. There were also inconsistencies in how events were recorded in his medical records, and communication between prison staff and healthcare was inadequate. The clinical reviewer concludes that the management of his clinical care was therefore "compromised".

76. The man's family received a copy of the draft version of the report as part of the consultation process. They raised concerns at the differences in how his injury was reported and recorded within prison documentation and how it differs from the information given to them by him, including the 'agony' he was experiencing. The man's family are concerned this resulted in inadequate examination of his injury and assumptions being made by staff. The man saw healthcare staff and doctors at Preston and complained of increasing pain in his shoulder. Whilst the clinical reviewer thinks that the initial diagnosis of a musculo-skeletal injury was reasonable, there was a long delay before he was referred for an orthopaedic diagnosis. The referral was not made until 2 September by a doctor at Wymott, approximately 16 weeks after the man first told a doctor that he had pain in his shoulder.

77. Whilst I am aware of the considerable pressures on prison and healthcare staff, I am concerned that, despite seeing a prison doctor on at least four occasions at Preston and five occasions at Wymott, the man was not referred

for a specialist diagnosis more quickly. The clinical reviewer said it would be expected that, following a third or fourth visit for the same problem, a referral to a specialist for investigation would usually have been made.

The heads of healthcare at Preston and Wymott should ensure that all healthcare staff are reminded of the importance of regularly reviewing medical records and that make timely and appropriate referrals for secondary diagnosis.

78. Following his initial health screening at Preston, the man was seen just over a week later. During that period, he seemingly lost 7.7kg, or over 10 per cent of his body weight. This may have been an early indicator of an underlying problem but it was never explored. It is not sufficient that such stark changes are simply recorded unless staff continue to monitor or arrange for further investigative work to be undertaken.

The head of healthcare at Preston should ensure that staff note when there are noticeable and measurable changes in a prisoner's anatomy and ensure that appropriate further investigations are undertaken.

79. The man told his family that he waited two weeks before he first saw a doctor at Preston after he injured his shoulder, due to a long waiting list. My investigator spoke to the Assistant Director for Prisoner Health for Preston, Wymott & Garth prisons to establish how prisoners apply to see a prison doctor, and whether a record is kept of when applications are made to confirm if the man's application was delayed. She advised that, once an application is received, it is entered on the medical electronic record and a doctor's appointment is allocated. However, whilst the date when the appointment is allocated is auditable, the original paper application is destroyed and thus the date when the form was submitted cannot be clarified. The issue of long waiting lists was raised in the inspection report in 2009, when prisoners reported waiting a similar time for appointments (although inspectors found that the usual wait was six or seven days). The length of waiting time to see a doctor was also raised as a matter of concern by those interviewed as part of this investigation. Therefore, given my findings and those of HMIP, I make a recommendation.

The head of healthcare at Preston should ensure that there is a robust system in place for prisoners to be able to make timely appointments to see a doctor.

80. The man was examined by the second agency doctor on 30 July, when he recorded that there was some deformity to the man's shoulder. Whilst a referral for physiotherapy had been made some weeks previously, this was another opportunity when the man could have been referred for further orthopaedic investigations. When the investigator interviewed the third doctor, he suggested that there is some pressure to avoid outside hospital referral due to the impact on staffing numbers and cost from arranging escort officers, which was also mentioned by the second agency doctor. However, both doctors maintained this would not deter them from making a referral and

were both aware that they could utilise the Telemed system (a video link system with a hospital whereby a second opinion can be sought), had they thought the man's condition warranted further investigation.

81. The man was referred for physiotherapy but he never received an appointment, although I accept that the Prison Service has no control over the acute hospital trust waiting times with regard to musculoskeletal physiotherapy and a routine referral could have been up to 18 weeks. A request in August for blood tests to be undertaken was not completed. It is important that there is a system to ensure that referrals result in actual treatment for prisoners.

The head of healthcare at Wymott should ensure that there is a robust process to ensure that all requests for treatments and tests are followed up and completed.

82. On 2 September, the second agency doctor made an urgent referral to the orthopaedic consultant and blood tests were requested again. An appointment was made for 14 October, much later than the doctor said in interview that he envisaged. However, hospital policy for urgent referrals is six weeks (unless cancer is suspected but in the man's case he was diagnosed with a musculo-skeletal problem).

83. Following his transfer to Wymott, the man was seen by a prison doctor on five occasions for the same symptoms. In the IMB report published in May 2010, concerns were raised about the use of agency doctors and the lack of consistency which might result. The IMB reported that they had observed an improvement in reduced waiting times to see a doctor at Wymott, but that access and consistency would need to be improved to be comparable to the service which is available in the community. Whilst seeing three doctors over a period of time is not uncommon in large community practices, consistency of provision should be promoted. I understand that there have been changes to the provision of doctors at Wymott since the man's death. This change is coincidental and not related to the man's death. Although I am pleased that the changes have occurred, the head of healthcare will wish to satisfy herself that they have led to a more consistent approach.

84. A letter from the Royal Preston Hospital clearly states that the man was very unwell when he arrived at the hospital for what was expected to be a routine orthopaedic appointment. He had a "palpable mass" on his shoulder and back. I believe that there were a number of opportunities missed for a timelier referral for a specialist diagnosis, following the examinations and assessments by the various agency doctors.

The heads of healthcare at Preston and Wymott should ensure that all healthcare staff have sufficient opportunity and are reminded of the need to access and review patient notes prior to any examination and medical assessment.

Prescribed medication

85. The man's family raised their concern that he was not taken seriously when describing the level of pain he was enduring, because of his history of substance misuse. Medications that are opiate based are not generally prescribed within prisons as they can be misused or traded and the prison doctors have a responsibility to ensure, as far as possible, that any prescribed medication is for legitimate use. I am satisfied that there is no evidence from the interviews that the man's history adversely influenced the doctor's prescribing decisions. The clinical reviewer considers that the pain relief medication was appropriate for the condition that had been diagnosed by the prison doctor. Nevertheless, had specialist assessments been made earlier, I think it is likely that his medication would not have remained the same. In my experience, controlled drugs such as morphine are often safely administered to terminally ill prisoners, as the man turned out to be.

Record keeping

86. I have found several examples of poor clinical record keeping. There is evidence in the man's prescription file, which he referred to in his correspondence to his family, that he was examined by a doctor and prescribed pain relief medication in April and May whilst at Preston. However, there are no corresponding entries in his electronic clinical notes. There are other examples of poor record keeping as previously mentioned and evidence that routine referrals were not followed up. The clinical reviewer states in the conclusion of her report that there were 'poor documentation standards contributing to a breakdown in the ongoing continuity of communication care and subsequent medical management/care'.

The heads of healthcare at Preston and Wymott should ensure that all healthcare staff, irrespective of status, comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

87. From interviews with prison staff and a prisoner who lived next door to the man, there was evidence that the man was well supported on his residential wing. Fellow prisoners collected his food and cleaned his cell, and officers ensured that they were able to do this. Officers also made contact with healthcare staff and raised their concerns about the level of pain the man was experiencing. However, there are very few entries in the wing history record which show the frequency of contact or level of care which was demonstrated by staff. Their care has only become apparent from talking to staff since the man's death. During interviews with staff, some raised concerns that they were having difficulty accessing the new prison computer system, known as P-NOMIS, because of a lack of terminals on the wing. It is important that records of contact with prisoners are kept and updated regularly.

The Governor of Wymott should ensure that all staff have regular access to the wing history sheet function on PNOMIS.

Communication between healthcare and wing staff

86. My investigations often comment on the absence of communication between wing and healthcare staff. The investigation into the circumstances of the man's death has found that some staff were well intended. For example, prison officers told healthcare staff at both Preston and Wymott that the man was in pain and discomfort. Unfortunately, for the reasons I have already described, this seems to have had little effect and no further investigations were made other than for a musculo-skeletal injury. During interview, the first officer from Preston gave a detailed account of her contact with healthcare staff and her concern about the man's health and there is written evidence in the wing history sheet of this communication. Conversely, on 16 August, the third asked wing staff to observe the extent of the man's shoulder pain and the restricted movement by his shoulder. However, there was no formal exchange of information from wing staff to the healthcare centre and no record of the request being followed up. This was another opportunity lost to better manage the man's pain.

The Governors and Heads of Healthcare at Preston and Wymott should ensure that there are clear lines of communication between healthcare and prison staff, and that requests for information are completed when appropriate.

Restraints and release on temporary licence

87. After the man was diagnosed with a terminal illness on 16 October, a further risk assessment was conducted to establish the appropriate level of restraints. I am pleased to note that the restraints were removed at this point, which is a proportionate response. It meant that he could move freely in bed and did not experience the indignity of being chained to a bed watch officer as he reached the end of his life.

88. I am also pleased that shortly after the risk assessment, consideration was also given to releasing him on temporary licence while his treatment continued. This meant that there were no uniformed bed watch staff with the man and he and his family had some privacy. Although he died much sooner than had been expected, because of pneumonia, I hope that this decision was of some comfort to his family.

89. However, what is not clear is that there was an established line of communication between the hospital and prison after he was released on ROTL. Consideration could have been given to appointing a family liaison officer at an earlier stage when it became clear that the man was terminally ill. This might have resulted in an earlier decision regarding an application to release him on compassionate grounds. Once appointed, the family liaison officer followed the guidance as set out in the PSO 2710, following a death in custody. Although I do not make a recommendation in this regard, the

Governor may wish to consider allocating a family liaison officer whenever a prisoner is likely to die soon.

90. If the man had been diagnosed with a terminal illness at an earlier stage then he could have applied and been considered for compassionate early release, to spend time with his family in his final months. However, there is no certainty that any application would have been approved.

91. The man's family following review of the draft report reflected their disappointment that my investigation does not explicitly state that prison and medical staff did not exercise a duty of care and have escaped sanction. Throughout this report I have highlighted the issues and summarised my conclusions in paragraph 92.

CONCLUSION

92. The clinical reviewer judges that the man received clinical care which fell below that which he could have expected in the community. I do not think that his complaints about his shoulder pain were followed up properly and as a consequence the real explanation was not diagnosed. It may be that taking methadone as part of a detoxification programme meant that his symptoms were masked. Whilst it is unlikely that with earlier detection the prognosis would have changed, I believe that the level of pain the man experienced could have been managed much better.

93. I am satisfied that the man was treated with dignity and respect following the diagnosis of terminal cancer and he was appropriately released at the earliest opportunity on temporary licence, although his family were disappointed that this was not done sooner. Following his death, the prison appropriately followed the guidance given in PSO 2710, "follow up to death in custody".

RECOMMENDATIONS

1. The heads of healthcare at Preston and Wymott should ensure that all healthcare staff are reminded of the importance of regularly reviewing medical records and that make timely and appropriate referrals for secondary diagnosis.

   Accepted - *Staff will be reminded to review the previous entries within the clinical record when reviewing a patient.*

2. The head of healthcare at Preston should ensure that staff note when there are noticeable and measurable changes in a prisoner's anatomy and ensure that appropriate further investigations are undertaken.

   Accepted - *Staff will be reminded to review the previous entries within the clinical record when reviewing a patient; they will be reminded to pay particular attention to previous baseline measurements e.g. weight and will be required to act upon any significant changes.*

3. The head of healthcare at Preston should ensure that there is a robust system in place for prisoners to be able to make timely appointments to see a doctor.

   Accepted - *The application and appointments system is currently being reviewed*.

4. The head of healthcare at Wymott should ensure that there is a robust process to ensure that all requests for treatments and tests are followed up and completed.

   Accepted - *Partner agency now fully aware of the local process – protocol in situ.*

5. The heads of healthcare at Preston and Wymott should ensure that all healthcare staff have sufficient opportunity and are reminded of the need to access and review patient notes prior to any examination and medical assessment.

   Accepted - *Staff will be reminded to review the previous entries within the clinical record when reviewing a patient.*

6. The heads of healthcare at Preston and Wymott should ensure that all healthcare staff, irrespective of status, comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted - *We have now moved to a fully electronic system.*

7. The Governor of Wymott should ensure that all staff have regular access to the wing history sheet function on PNOMIS.

Accepted - *This recommendation will be factored into future IT reviews.*

8. The Governors and Heads of Healthcare at Preston and Wymott should ensure that there are clear lines of communication between healthcare and prison staff, and that requests for information are completed when appropriate.

   Accepted - *An information sharing protocol and related staff referral form will be developed which will improve the communication between Prison and Healthcare staff to enable concerns/issues raised to be handed over and appropriate action taken*