Investigation into the circumstances surrounding the death of a man, following his release on temporary licence from HMP Littlehey, in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Littlehey. The man died on 29 January 2009 at a local hospital. I offer my sincere sympathy and condolences to his family, and all those affected by his loss.

The man died two days after being released from prison on temporary licence. His early release was arranged because of his ill health. The cause of death was established as bronchopneumonia due to multi-organ failure, with a secondary condition of testicular teratoma (cancer).

The investigation was carried out by my colleague. An independent review of the man's medical care in custody was carried out by Ms E and Dr C on behalf of the local Primary Care Trust. I am most grateful to Ms E and Dr C for their assistance.

I would also like to thank the Governor and staff of Littlehey for their full and ready co-operation during the course of the investigation. I am especially obliged to Ms B, the deputy governor, for her help in liaising with the investigator.

The man who died was remanded to HMP High Down in November 2007 but, despite being treated for testicular cancer less than a year earlier, chose not to reveal his diagnosis to prison staff. Several opportunities were missed to find out more about his medical history in his early days in prison. As a result, prison staff were unaware of his history until he was diagnosed with a recurrence in September 2008. Amongst my eight recommendations, four are aimed at improving reception procedures at High Down.

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

Jane Webb
Deputy Prisons and Probation Ombudsman **January 2010**

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SUMMARY

The man who is the subject of this report was diagnosed with testicular cancer in late 2006, before he came into custody. He underwent surgery in December 2006, during which one of his testicles was successfully removed. For reasons that are unknown, he did not attend any of the three follow up appointments that were sent to him.

In May 2007, the man was remanded into custody at HMP Belmarsh. On his arrival, he told a nurse about his recent diagnosis. He was later seen by a prison doctor who noted that he still required follow up. After attending court the following day, he transferred to HMP High Down. He was released from prison in August 2007 with no referral having been made.

The man was again remanded into custody, for a separate offence, on 2 November, and returned to High Down. On this occasion, he did not disclose his history of cancer. I am unable to say why this was. He had been in custody several times previously and so was familiar with the routine reception health screen. Several opportunities were missed in his first days in custody to obtain details of his previous medical history. For instance, his doctor in the community was not contacted and his previous prison medical record was not recalled. As a result, no one in the National Offender Management Service was aware that the man had recently had testicular cancer until he was diagnosed with a recurrence nearly 11 months later. I make four recommendations to the head of healthcare at High Down regarding their reception procedures.

Around four months after his arrival at High Down, the man asked to see a prison doctor after experiencing what he called a “cold feeling” in his groin. He told the doctor that he had previously had testicular cancer, but said that he was diagnosed in 1996 rather than 2006. Again, I am unable to explain why he might have said this. The doctor did not detect anything abnormal.

The man transferred to Littlehey on 30 May 2008. He did not tell anyone at the prison about his history of cancer, either at his routine screening assessment or later. After experiencing chest pain on 16 September, he was admitted to hospital where he was diagnosed with a recurrence of testicular cancer which had spread to his right lung. Nevertheless, his prognosis was thought to be good. Over the next three months, he completed four cycles of chemotherapy. During his stays in hospital as an inpatient (usually for five or six days at a time) he was not able to watch the hospital television set because he had no private cash and his prison weekly allowance was not enough to pay for the service. I make a national recommendation about this.

During his final cycle in December, scans revealed that the man had developed fibrosis (a disease of the lungs) as a side effect of the anti-cancer medication he was taking. His lung function did not improve and, at a follow up appointment on 14 January 2009, he was admitted as a hospital inpatient for treatment. Six days later he suffered a partially collapsed lung and, two days after that, the man was thought to be very close to death. He remained

in a critical condition and, following a further deterioration on the evening of 28 January, he was pronounced dead at 1.52am on 29 January.

Although the report is critical of the failure of prison staff to identify the man's history of cancer, significant responsibility must also lie with the man himself for hiding his medical history. Nevertheless, I cannot say that there would have been a different outcome had prison staff been aware of his cancer treatment in 2007.

THE INVESTIGATION PROCESS

1. The investigation was opened on 30 January 2009, when the investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No prisoners or staff came forward as a result.

2. The investigator was given access to the man's prison files, including the medical record. He also arranged for access to his medical record from a previous time in custody. The investigator visited Littlehey on 22 April and, with the assistance of my colleague Mrs L, interviewed four members of staff. He also visited HMP High Down on 30 April and interviewed a further four members of staff.

3. An independent clinical review of the man's health needs whilst he was in custody was carried out by Ms E and Dr C on behalf of the local Primary Care Trust. Ms E joined the investigator and Mrs L at Littlehey on 22 April.

4. One of the Ombudsman's family liaison officers wrote to the man's sister on 26 February 2009, to inform her of the investigation and invite his family to raise any issues they wished the investigation to address. At the time of writing this report, the man's family had not raised any issues about his death. I hope that this report helps to clarify any issues that might remain unclear for his family and helps them to better understand what happened in the time leading to his death.

HMP LITTLEHEY

5. Littlehey is a category C prison for convicted and sentenced adult males. The site currently consists of eight residential units providing a capacity of 726 places. In addition, four new accommodation blocks are due to open in January 2010, to accommodate up to 480 young offenders.

6. Health services at Littlehey are commissioned by the local Primary Care Trust. A local community practice provides GP clinics at the prison six days a week. A nursing team works on site during the day on weekdays and on Saturday mornings. At other times, advice is available through an out of hours service. There are no inpatient beds at Littlehey.

7. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. This is to determine the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff will carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch will be carried out by a duty governor. Visits from family may be allowed but these will be closely monitored to ensure that they do not impinge on the security of the bedwatch. The risk assessment will consider factors such as the prisoner's medical condition, the nature of their offence and their risk to the public.

8. Littlehey was last inspected by HM Chief Inspector of Prisons in July 2007. She found that health services at Littlehey were "adequate", but considered some waiting lists to be too long. She described Littlehey, in summary, as an "impressive and improving" prison.

9. The Independent Monitoring Board report for 2008-2009 found that healthcare at Littlehey continued to "operate well". They thought that, overall, Littlehey was a "well run establishment, where prisoners live in a safe and respectful environment".

10. The man's death was the 11th to occur at Littlehey since April 2004, when the Ombudsman began investigating all deaths in custody in England and Wales. All but two of the previous death were due to natural causes. There have subsequently been three further deaths at Littlehey, two of which were due to natural causes. The Ombudsman's reports into these previous deaths have generally reflected well on Littlehey and make no recommendations which are relevant to the circumstances of the man's death.

HMP HIGH DOWN

11. Opened in 1992, HMP High Down was originally a local prison but in 2003 also took on the role of a category B training prison. The establishment consists of six houseblocks, with a capacity of around 1,100 prisoners.

12. Healthcare at High Down is commissioned by the local Primary Care Trust and provided by the local Community Health Trust. Local Forensic Medical Services provide GP cover at the prison. The healthcare centre includes an inpatient wing with a capacity of 23 places. A day care facility and a wide range of primary care services are also provided.

13. High Down was last inspected by HM Chief Inspector of Prisons in May 2009. She found that all but two of the recommendations regarding health services she had made following her previous inspection, in May 2006, had been achieved. She reported that each houseblock had a dedicated nurse and primary care treatment facility, although staffing levels were just adequate.

14. The Independent Monitoring Board report for 2008 warned that the GP service at High Down had "not provided a consistent and timely service". They also reported that some clinics were under threat because of a budget cut at the Primary Care Trust.

15. There have been ten deaths at High Down since April 2004, of which two have been due to natural causes. The Ombudsman's report into the most recent of these two deaths, which occurred in May 2008, found that the first reception health screen was completed appropriately. Some boxes were left blank in the man's case.

KEY FINDINGS

16. The man who is the subject of this report was diagnosed with testicular cancer in 2006. He had surgery in December 2006 to remove his right testicle. The man was subsequently referred for follow up but did not attend the three appointments that he was offered. A letter from his consultant at Farnborough Hospital, dated 5 February 2007, indicated that the cancer was confined to the man's testes and that removing the right testicle should have cured the disease.

17. The man was arrested on 15 May 2007, and spent the next three nights in police custody. He told the police doctor that he had testicular cancer and had been treated for this at hospital just after Christmas. After appearing in court on 19 May, he was remanded in custody to Belmarsh.

18. Following his arrival at Belmarsh, the man was seen by a nurse for a first reception health screen (a routine health screen for all new arrivals into prison). He told the nurse he had been treated for testicular cancer in February 2007. The man also said that he was diabetic and had high blood pressure. Four days later, staff at Belmarsh faxed both the hospital and the man's doctor in the community to request details of his medical history. The consultant's letter of 5 February, referred to in paragraph 6 above, was sent to the prison. During an appointment with the man on 24 May, a prison doctor noted that, although the tumour was confined to the removed testicle, the man required a follow up appointment with an oncologist (cancer specialist). He noted that the man was due to attend court the next day and there was a 50 per cent chance that he would be released. The prison doctor added that, were the man to return to Belmarsh after court, he would refer him for follow up by the local oncology services.

19. At his court appearance the following day, he was denied bail. However, he returned to High Down rather than Belmarsh. He was seen by a nurse in reception at High Down, who referred him to a prison doctor for follow up "asap". Despite this, there is no record of the man seeing a doctor for several days. He was held in the segregation unit at High Down during his first week at the prison. This was because he had requested 'vulnerable prisoner' status (meaning that he had asked to be separated from other prisoners for his own safety) and there was no space in the vulnerable prisoners unit. It is not clear how often he was seen by a prison doctor whilst in the segregation unit. The only recorded assessment was on 1 June, when the man was noted to be "fit" during a routine segregation unit review. No mention was made of his cancer or of any need for follow up.

20. The man was admitted to the healthcare centre for observation on 12 July after reportedly taking an unknown quantity of diazepam (usually known by the brand name Valium and taken to treat anxiety disorders). The man's admission note included information relating to his cancer diagnosis in December 2006. It is not clear how long he remained an inpatient. He

was subsequently released from custody on 3 August 2007. The referral to an oncologist was not made during this period of imprisonment, despite the entry made by the prison doctor at Belmarsh on 24 May.

21. On 2 November, the man was remanded into custody for a separate offence and went to High Down. As is customary, he was given a new prison number. His records were not linked to those of his previous imprisonment a few months previously. A first reception health screen was carried out on his arrival by Nurse V. The man told the nurse he was diabetic and had previously experienced a painful leg. There is no record that he mentioned his history of testicular cancer at any point during the consultation.

22. One question on the reception health screen form asks, “Have you seen a doctor in the last few months?” to which the man answered “yes”. The box below, in which an explanation for this consultation should be provided, is blank. Nurse V told the investigator that he did not recall whether the man elaborated on why he had seen a doctor recently.

23. A later question asks, “Do you think there is a reason why you might need to see a doctor?” Although he answered “yes” to this question, the “referred to doctor” tick box on the next page is blank. Nurse V told the investigator that he thought it was probable that the man wanted to see a doctor because of his diabetes. He added that there is a follow up form that would be automatically completed by the reception nurse if the prisoner was to be referred to a doctor. However, it is not clear whether this form was completed (it is not in his medical record). There is no indication of the man having a consultation with a prison doctor in his first weeks in custody, other than on 7 November when he was seen in the segregation unit (he was waiting for a space on the vulnerable prisoners unit) and again described as “fit”.

24. During his reception screen, the man told Nurse V he was taking diazepam, as well as metformin and gliclazide (medications to control diabetes). The following day, a member of healthcare staff telephoned his community doctor’s surgery to confirm his medication. The surgery was not available. It does not appear as though any further attempt was made to contact his community doctor. Nevertheless, both metformin and gliclazide were prescribed by a prison doctor. It does not appear from his prescription chart that he was prescribed diazepam.

25. The man attended a well man clinic (a general health check for men) on 23 November, with Nurse M. A question on the front page of the assessment form asks, “Do you or any member of your family suffer from any serious illness?” Examples of serious illnesses, including cancer, are given. The form requires an answer of either “yes” or “no” to be circled, with space provided to give more details should the answer be affirmative. No answer is given on the man’s form. Nurse M told the investigator that she would have asked this question but could not say why she had not circled an answer. She did not remember how he answered the question.

26. A later question asks whether the patient is aware of the need to do a testicular self-examination. The man answered “yes” to this, but did not take the opportunity to reveal his medical history. Nurse M said that she would usually expand on the question and ask the patient to describe how they would examine themselves. However, she said that he did not mention his previous history of cancer at any point during the clinic.

27. Three days later, the man attended a clinic with Nurse H, a diabetes nurse. A blood test taken showed that he had a high blood sugar level. As a result, Nurse H increased the strength of his metformin prescription.

28. On 12 December, he was seen by a prison doctor as his recent blood test had revealed high lipids (indicating high cholesterol). The doctor prescribed a course of simvastatin (medication to reduce cholesterol). He also complained of heartburn in the evenings and was prescribed omeprazole to treat this. Five days later, he attended the diabetes clinic for a second time. Nurse H increased his dose of gliclazide.

29. At his next clinic with Nurse H, on 23 January 2008, it was noted that the man had not been taking his gliclazide tablets. (It is not specified why he was not taking this particular medication.) It was consequently removed from his prescription, with his dose of metformin increased as an alternative.

30. The man was seen by Dr P at a genito-urinary medication (GUM) clinic at High Down on 11 March. Dr P made an entry in his medical record saying, “cold feeling right groin above scar from previous cancer testicle”. In interview with the investigator, Dr P explained that she kept a more detailed note of this examination herself. Her practice was not to include detail in the medical record for reasons of patient confidentiality, as the clinic dealt with sexually transmitted diseases.

31. Dr P explained that the man told her about his previous history of testicular cancer. However, he told her he had been diagnosed in 1996 rather than 2006. He said that he had been treated at hospital and had not had chemotherapy. Dr P told the investigator that there was no suggestion by the man that he had had cancer any later than 1996. She examined him and found nothing abnormal. Dr P told the investigator that she thought he might have a trapped nerve and there was nothing to make her think that he might have another cancer appearing in his remaining testicle. She did not think that any follow up was needed.

32. The man was sentenced to three years imprisonment on 21 April. A month later he attended an outpatient appointment at an eye clinic at the local hospital. The outcome of this appointment is not noted in his record, although he was given a new pair of glasses the following day.

33. On 30 May, the man transferred to Littlehey. He had a reception health screen on his arrival at the prison, with Nurse C. The reception screening

form for prisoners transferring in from another establishment is unique to Littlehey. The patient is asked various questions about their medical history including whether they are diabetic, to which the man answered in the affirmative. There is no question on the form relating to cancer, and no space for the interviewer to ask for or add any additional information. However, Nurse C told the investigator that she would always ask the patient if there was anything they wished to add. She recalled that the man did not add anything and made no mention of his history of testicular cancer.

34. The man who died saw a prison doctor, Dr R, twice during his first ten days at Littlehey. On the first occasion he was given advice about stopping smoking and, on the second occasion, they discussed the man's medication for diabetes. Over the next six weeks, he was seen by healthcare staff on a couple of occasions after suffering constipation. On 4 July, he was excused from work after complaining of feeling unwell.

35. On 22 July, the man went to the healthcare centre and asked to see a doctor. He was told that he had to follow the correct procedures and put in an application for an appointment with the doctor. He duly completed an application, and an appointment was made with Dr R for 25 July. At the appointment, he told Dr R that he had been feeling light headed for three days. He had no other symptoms. Dr R checked his blood pressure, which was normal. The man also said that he was not always getting his diabetic pack (specific foods to help lower blood sugar levels) from the kitchen. Dr R sent a memo to the kitchen requesting that they supply the diabetic pack as required. He did not prescribe medication or schedule any further follow up.

36. In early August, the man's thumb became infected. On 5 August, he had a minor operation at the prison under local anaesthetic, in which fluid was drained from the thumb. He was given a course of antibiotics and, after a week, his thumb was noted to be much improved.

37. Shortly before midnight on 16 September, the man called an officer to his cell and said that he had pain in the right side of his chest and was struggling to breathe. After consulting the on call doctor over the telephone, the officer requested an emergency ambulance. He was taken to a local hospital.

38. The man was diagnosed with pneumonia and a recurrence of testicular cancer which had spread to his right lung. Despite the recurrence, his prognosis was reported to be good. He was discharged from hospital on 25 September with a follow up appointment to see an oncologist four days later. His chemotherapy could start as early as the day after this appointment.

39. On 29 September, the man went to his appointment with Mr W, a consultant oncologist at a hospital in the area. Mr W thought there was a high probability that the cancer was curable and arranged for the man to

undergo three cycles of chemotherapy, starting on 3 October. (This was later increased to four cycles.) During the meeting, the man expressed concern about future infertility and an appointment was therefore made at a local fertility clinic for the following day.

40. After seeing the man, the oncologist wrote to the Governor of Littlehey about the significant risk of side effects that the man faced during his treatment. Mr W specifically mentioned the risk of neutropenic sepsis, the development of infection due to a low white blood cell count. He stressed that, if the man were to become suddenly unwell and his temperature rose above a particular level, then he should be admitted to hospital as an emergency. This information was subsequently passed in a memo from healthcare to C wing staff.

41. The man attended the fertility clinic on 30 September, and provided a semen specimen that was frozen and stored. Two days later he was admitted to hospital in preparation for the first cycle of chemotherapy that was due to start the following day. Each cycle consisted of a five to six day inpatient stay, followed by outpatient follow ups for the administration of bleomycin (medication used for the treatment of cancer) at weekly intervals. He completed the first part successfully and was discharged back to Littlehey on 10 October.

42. Five days after his discharge, he reported severe pain in his chest and lower back. He was prescribed co-codamol (a strong painkiller) and, when the pain was only slightly better the following day, he was given a patch to wear (for stronger and faster pain relief). The next day, the man attended hospital for his scheduled outpatient appointment as part of the first cycle of chemotherapy.

43. The man returned to hospital on 24 October to begin his second cycle of chemotherapy. He was said to be “comfortable and chirpy” during his stay in hospital, before being discharged to Littlehey on 31 October. A discharge summary was faxed to the prison, listing the medication prescribed by the oncologist. As some of this medication was not usually stocked in the prison, the pharmacist contacted the hospital and asked them to send medication back with him in future.

44. A week later, the man returned to hospital for his outpatient follow up. On 10 November, he complained again of lower back pain and was given more pain relief patches by Dr R. His next cycle of chemotherapy started on 14 November. He successfully completed the cycle over the course of a six day inpatient stay and had a follow up outpatient appointment on 28 November.

45. On 5 December, the man was admitted to hospital for his final cycle of chemotherapy. The cycle was completed, although scans taken at the hospital indicated that he was developing fibrosis (disease affecting the tissue in the lungs). This was thought to be a side effect of the bleomycin that he had taken at his outpatient appointments during the previous

cycles of chemotherapy. He was prescribed a course of prednisolone (an anti-inflammatory steroid) to counter the fibrosis. As a result of these complications, he stayed in hospital longer than previously and was not discharged until 17 December. A course of prednisolone was added to his medication list on discharge.

46. The man attended a follow up appointment with Dr A, a consultant in respiratory medicine (lung specialist) at the hospital, on 24 December. In her discharge letter to Littlehey, Dr A wrote that she was "concerned" about the man and that his lung function (a test of how well the lungs work) was slightly worse than previously. In addition, the man told Dr A that he was only being given one 5mg tablet of prednisolone a day at the prison, whereas his prescription was for 40mg a day. Dr A telephoned the prison pharmacy, who told her that the prescription for 40mg was being dispensed as instructed. This is supported by the man's prescription chart, which shows that he was given 80 tablets of prednisolone on 18 December. A copy of the label is attached to the prescription chart with the instruction that eight tablets should be taken each morning to make up the 40mg dose. It does not appear as though he made any further complaints about missing medication.

47. After experiencing shortness of breath on the afternoon of 1 January 2009, the man was admitted to hospital as an emergency patient. He was given medication including salbutamol (to help the airways open), before being discharged on the same day.

48. A follow up appointment with Dr A was booked for 14 January. However, there was an apparent breakdown in communication between the hospital and the prison, which led to staff at the hospital thinking that Littlehey had cancelled the man's appointment. Due to staffing restrictions at Littlehey, as at all prisons, the number of prisoners who can attend an outpatient appointment on any given day is limited. It is usually the case that two members of staff escort a prisoner to hospital. At Littlehey, two prisoners may attend appointments in the morning and a third may go to an appointment in the afternoon. If more hospital appointments are offered on the same day than there are slots available, prison healthcare staff must prioritise the most urgent consultations and re-book the others.

49. On 6 January, Mr W sent an urgent fax to the Governor to say that Dr A had been told that the prison were not going to send the man to his appointment on 14 January, due to staff shortages. Mr W wrote that it was "completely unacceptable" that the man should miss a clinic for a "life threatening (but) eminently treatable" condition.

50. Ms Y, an administrative assistant at Littlehey responsible for outpatient appointments, wrote a memo to the healthcare manager on 7 January. Ms Y wrote that they had been treating the man's appointments as a priority since his diagnosis in September 2008. In this case, there were already two appointments scheduled for the morning of 14 January when the man's was received. Ms Y said she had therefore contacted the

hospital on 30 December to discuss the situation with them. In a second call to the clinic manager at the hospital a few days later, Ms Y had confirmed that the man would attend his appointment on 14 January. Ms Y said that the hospital should therefore have been aware of this before Mr W's fax of 6 January.

51. On 12 January, Ms R, the nurse manager at Littlehey, sent a fax to Dr W to emphasise that the man would attend his appointment. Ms R added that they were "extremely aware" of the need for him to attend his appointments and apologised for any breakdown in communication.

52. The man duly attended his appointment with Dr A on 14 January. Dr A noted that she was "increasingly concerned" about him. He had become "increasingly breathless on minimal exertion" and his lung function had declined since his last consultation. Dr A arranged for the man to be admitted to hospital as an inpatient so that he could receive prednisolone intravenously. As with the escort arrangements during his chemotherapy cycles, he was accompanied by two officers at the hospital and cuffed to one of these by means of an escort chain (a long chain with a handcuff at each end).

53. Six days later, the man suffered a partially collapsed lung. His condition did not improve and, at lunchtime on 22 January, the escort chain was removed. Later that afternoon, his sister was contacted and informed of his condition by prison staff. He deteriorated further during the afternoon and the escorting staff were told that he might not live through the night.

54. Despite the fears of hospital staff, the man remained in a stable but critical condition over the following days, although he was unconscious. His condition improved slightly over the weekend (24-25 January), but deteriorated again on 26 January. On 27 January, he was released on a temporary licence (ROTL, a temporary release from prison, in this case for compassionate reasons because of his very poor health). This allowed Littlehey to reduce his escort to one officer with no handcuffs in place. The officer sat outside the ward to allow the man and his visitors some privacy.

55. The man improved a little during the evening of 27 January, although he remained unconscious. However, his condition deteriorated significantly the following afternoon and his family were told of this turn of events by a prison family liaison officer. Two officers were present that evening, as several members of the man's family were due to visit.

56. Over the course of the evening, the man's condition continued to deteriorate. He was pronounced dead at 1.52am the following morning. As had been agreed with his sister during her visit that evening, a nurse at the hospital telephoned her to break the news of his death.

57. A post mortem examination was not deemed necessary by the coroner. However, the cause of death was established as bronchopneumonia due to multi-organ failure, with a secondary condition of testicular cancer.

58. The man's funeral was held on 4 February, and was attended by Senior Officer (SO) D, the prison's family liaison officer. The investigator found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Oncology follow up during imprisonment in summer 2007

59. The man who died was diagnosed with testicular cancer in late 2006. His right testicle was removed during an operation on 22 December 2006, which was believed to have cured the disease. However, he did not attend any of the follow up appointments that were booked for him in early 2007. These were all at a time when he was at liberty in the community.

60. On 19 May 2007, the man was remanded into custody to Belmarsh. He was seen by a prison doctor five days later, who noted that he needed a follow up appointment with a cancer specialist. He attended court the following day, after which he went to High Down rather than Belmarsh. He was released from prison on 3 August with no follow up appointment having been made during this time.

61. The clinical reviewer, Dr C, considers this a missed opportunity to arrange follow up for the man. His opinion is that a clear summary of his past medical history at the front of his medical record would have allowed High Down to determine, from reception onwards, an action plan for dealing with the previous cancer.

62. Many prisons, including Littlehey, use an electronic system for recording patient's medical details. The 'System One' software used at Littlehey includes a summary of the patient's medical history and current conditions on the front page. The head of healthcare at High Down, Ms D, told the investigator that they have made a business case for System One software and hope to progress this in 2010. I would urge them to pursue it vigorously.

63. Although Dr C feels that a summary of the man's medical history would have helped to identify the need to arrange oncology follow up, there were still several missed opportunities during his ten week spell at High Down. An entry was made during his reception screen immediately below that made by the doctor at Belmarsh on 24 May. The reception entry made no reference to the man's cancer, although it was noted that he needed to see a prison doctor at High Down "asap". This seemingly did not happen, other than a routine assessment in the segregation unit. Around seven weeks later, when he was admitted to healthcare on 12 July, the admitting nurse referred to his cancer diagnosis the previous year. Again, this did not prompt a referral for follow up.

64. Despite these missed opportunities for follow up, it was still over a year before the recurrence of the man's cancer was diagnosed. Dr C considers in the clinical review whether referring him for follow up in summer 2007 might have had an impact on his long term prognosis. He says that this "might have made a difference, but we would need to seek expert opinion on this".

65. The investigator therefore contacted Mr W, the consultant oncologist at the hospital who was in charge of the man's care following the recurrence of his cancer in September 2008. He asked Mr W for his views on the impact that any missed follow up in summer 2007 might have had on his long term prognosis and eventual death.

66. Mr W replied with the following opinion:

> "My view is that his death was the result of complications from his treatment with bleomycin, which is a rare but well recorded cause of death in one to two per cent of these patients. One could therefore argue that this might well have happened if his recurrence had been detected and the treatment initiated earlier and that therefore the failure to have follow up did not influence the outcome. There is, of course, also the issue of the patient's own responsibility in missing a series of earlier appointments which he had been sent from the hospital when he was not in prison."

Reception to High Down in November 2007

67. The man was remanded to High Down on 2 November 2007. The national mandatory 'first reception health screen' form was completed by Nurse V on the same day. His previous history of testicular cancer was not established at the reception health screen. I am unable to say why he did not volunteer this information himself, particularly as he had done so during a previous period of imprisonment just a few months previously. Nurse V told the investigator that he remembered seeing him on a few occasions during his previous time at High Down. However, his memory was of giving the man his medication for diabetes and he did not know that he had recently had cancer.

68. As I have described in paragraphs 21-23, some areas of the reception health screen form were left blank by Nurse V. This included a box in which the reasons why the man had seen a doctor in the last few months should be explained. Nurse V told the investigator that he could not recall if the man had answered this question. A later question asks the patient if there is a reason why they might need to see a doctor. He answered "yes" to this question. However the "referred to doctor" box on the next page is blank and it does not appear as though he had a formal consultation with a prison doctor during his first weeks in custody.

69. Dr C writes in the clinical review:

> "It is essential that preliminary paperwork is completed in full when a prisoner has a reception screening … There should be protected time for reception screening and the opportunity to continue on another occasion as soon as possible if necessary. As this is the foundation on which the medical screening of the prisoner occurs it is essential that time is given to be able to collect this information."

The head of healthcare at High Down should remind staff of the importance of fully completing the 'first reception health screen' form. She should also ensure that patients who need to see a doctor are referred appropriately by the reception nurse.

70. Prison Service Order (PSO) 3050 instructs that:

> "When a prisoner enters reception … efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

71. A few days after his reception to Belmarsh in May 2007, faxes were sent to both the hospital and the man's community doctor to request details of his medical history. Information pertaining to his diagnosis, treatment and missed follow up was returned. The day after his reception to High Down during the man's next period of imprisonment, in November 2007, a member of healthcare staff telephoned his community doctor's surgery to confirm his medication. The surgery was not available at the time, and it does not appear as though a second attempt was made to contact them. Staff at High Down did not therefore receive any information from outside sources about the man's medical history. This was another missed opportunity to uncover his recent cancer and also to confirm the types and levels of medication he was taking to control his diabetes.

72. The investigator asked Ms D about contacting a new prisoner's community doctor. Her response was as follows:

> "It is a regular occurrence. Obviously we won't do it if there's no history at all, they're fit and healthy young men with no issues. But if we have any concerns about medication, what their previous treatment has been … then in order to provide continuity of care we will contact [their] local GP … what we tend to do, as much as possible, is to fax doctors because then you've got written evidence of the fact that you contacted them."

73. It does not appear as though a fax was sent to the man's community doctor from High Down. Although staff were not aware of his history of cancer when he arrived as a new reception, he told them that he had diabetes and seemingly asked to see a prison doctor. My view is that it can only be beneficial for healthcare staff to have full access to the details of a patient's medical history, as instructed in PSO 3050.

The head of healthcare at High Down should remind staff to request community GP records for all new arrivals in prison, especially those who report a chronic disease or other serious condition in their medical history.

74. Prison Service Standard 22, regarding health services for prisoners, instructs that:

> "A discrete patient clinical record is opened for every prisoner on first reception and reasonable attempts made to merge this with records from previous periods in custody."

75. PSO 3050 also instructs staff that they should consider retrieving information from a prisoner's previous periods in custody "if indicated at reception". Nurse V recorded in the man's reception health screen that he had been released from prison in July 2007 and told the investigator that he remembered seeing him at High Down during that period of imprisonment. Despite this, his previous medical record was not retrieved and yet another opportunity to uncover his recent cancer was missed.

76. Nurse V told the investigator that they would usually link the previous medical record with the new record. This was not automatic but would be done by administrative staff if a prison doctor had requested it. Ms D said that they were reliant on the prisoner remembering their old prison number to be able to search for the record. She added that the prison based computer system (LIDS, Local Inmate Data System, used to record a prisoner's basic details, such as name, date of birth, offence, sentence length etc) does not store historical data after a prisoner is released and they would not therefore be able to use it to search for old records.

77. The introduction of System One to High Down should make it considerably easier to retrieve an individual's old prison medical records. Until this is established, the prison should review their systems to ensure that they are able to locate an individual's old records quickly and easily. Storing records by surname would negate the need for the prisoner to remember their old prison number.

    The head of healthcare at High Down should review the means by which old medical records are filed. She should ensure that previous medical records are retrieved for all new arrivals into prison who have been in custody during the previous 12 months.

78. Three weeks after his reception to High Down, the man attended a well man clinic at the prison. As I have described in paragraph 25, a question relating to the patient's history of serious illness was not completed on the form. The nurse who took the clinic told the investigator that she was unable to say why she had not completed the answer to this question.

79. PSO 3050 gives the following instructions to prisons:

> "In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the

community. Such assessments are not standardised, however the general health assessment should act as an opportunity for: gathering further medical information, checking how the prisoner is settling in, health education, providing information, health promotion."

80. Ms D told the investigator that the well man clinic is the same as this general health assessment. It is now included as part of the reception screening process at High Down. Ms D said that this was a more efficient system and enables them to provide more effective care from the first day of a patient's time in custody.

81. However this means that, contrary to the instructions of PSO 3050, a health assessment does not take place during the first week in custody. The benefit of such an assessment is that it takes place away from the pressurised environment of reception. It allows both the patient and healthcare staff to reflect on the first days in custody and raise any concerns that may have been missed at reception.

The head of healthcare at High Down should ensure that a general health assessment is offered during the first week in custody, in line with PSO 3050.

GUM clinic in March 2008

82. After experiencing what he described as a "cold feeling" in his groin, the man saw Dr P at a clinic at High Down on 11 March 2008. He told Dr P that he had previously had testicular cancer, but said that this was in 1996 rather than late 2006. I am unable to explain why he might have said this. After examining him, Dr P found nothing abnormal and did not think that any follow up was required. She told the investigator that, had he been truthful when he said how recent his cancer was, she would have ensured that he was attending hospital for follow up.

83. Dr P made minimal notes in the man's medical record and told the investigator that she kept a more detailed note of such consultations herself. She explained that she did not include detail in the medical record for reasons of patient confidentiality, because the GUM clinic dealt with sexually transmitted diseases.

84. Dr C considers Dr P's practice of keeping records separately, and makes the following comments:

"All medical records must be kept together. In exceptional circumstances a separate set of notes may be retained by a doctor but this is where the record may be highly confidential and this can be justified."

The head of healthcare at High Down should remind doctors who work at the prison to record full details of consultations in the medical record, other than in exceptional circumstances.

Reception screen at Littlehey

85. The man transferred from High Down to Littlehey on 30 May 2008. A reception health screen was carried out following his arrival at the prison. Unlike the 'first reception health screen' form, which is universal throughout the Prison Service for new entrants to prison, the reception health screen form for prisoners transferred from other establishments is not standardised. PSO 3050 allows each prison to "develop a local protocol and procedure … to meet its local needs".

86. The reception health screen at Littlehey was conducted by Nurse C, who completed the form in full. Whilst the form contains questions relating to some specific chronic diseases, including diabetes, there is no space for the patient to give any additional significant information about their medical history. Although Nurse C said she gave the man the opportunity to add to what they had already discussed, he did not do so and seemingly chose not to mention his history of cancer. Nonetheless, it would be helpful for space to be available on the form for additional information to be recorded.

    The head of healthcare at Littlehey should consider amending the reception health screen form to allow space for additional information about significant diseases or operations not covered elsewhere on the form.

Access to television in hospital

87. The man who died spent a substantial amount of time in hospital in autumn 2008 whilst undergoing chemotherapy. His first three cycles of chemotherapy involved spending five or six days in hospital on each occasion and he spent just under a fortnight in hospital during the final cycle of chemotherapy. Governor P, the head of operations at Littlehey, told the investigator that the cost of access to televisions in hospital in comparison with prisoners' rates of pay meant that the man was unable to watch television in hospital and did not therefore have anything to do. He had no private cash of his own to pay for television. Although he would have had access to books and magazines within the hospital, people undergoing chemotherapy treatment might not feel up to reading for long periods of time.

88. The national rates of prisoners' pay are set out in PSO 4460. For prisoners in hospital, pay is set at £4.35 per week. Many hospitals provide access to a bedside entertainment system provided by the private company Hospedia (formerly and more commonly known as Patientline). Patients may pay to watch television on this system, at a cost of £2.90 per day or £10.00 for five days. This is significantly more than the national rate of pay for prisoners and means that television is inaccessible for those who do not have access to private cash. (In contrast, prisoners pay £1.00 per week to rent a television to use in their cells.)

The National Offender Management Service should consider measures to allow prisoners' access to television during inpatient stays in hospital, where the prisoner does not have private cash of their own to meet the cost.

Release on temporary licence and early release on compassionate grounds

89. The man was released on temporary licence on 27 January 2009, for compassionate reasons because of his very poor health. This allowed his escort to be reduced to one officer, who was asked to sit outside of the room. This allowed him greater dignity and a chance to spend his final days in private with his family.

    The man was released on temporary licence shortly before his death. This allowed him to spend his final days in private with his family.

90. PSO 6000 describes the conditions and process by which a prisoner might be granted a permanent early release on compassionate grounds. The criteria for early release on medical grounds are as follows:

    - "the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and

    - the risk of re-offending is past; and

    - there are adequate arrangements for the prisoner's care and treatment outside prison; and

    - early release will bring some significant benefit to the prisoner or his/her family."

91. The PSO goes on to say:

    > "Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy."

92. The man suffered a partially collapsed lung on 20 January 2009. Two days later, his condition deteriorated significantly to the extent that the prison staff escorting him in hospital were told that he might not live through the night. He remained in a stable condition over the following 24 hours however, and improved slightly over the weekend of 24 January. His condition continued to fluctuate over the following days until, on 28 January, he experienced another significant deterioration. Hospital staff

were now very concerned about his condition and his family were contacted. He died in the early hours of the morning on 29 January.

93. Although the man was released on temporary licence, no application was submitted by Littlehey for the early release on compassionate grounds. The deputy governor, Ms B, told the investigator why they did not submit an application:

> "Everything happened so very quickly and certainly my own personal experience at compassionate release is that you don't get them done that quickly … the paperwork that you have to do is quite long winded and quite difficult and even getting the medical reports that go with it can sometimes take up to five to ten days.
>
> "Until he took that downward turn which was four days before [he died] then we probably wouldn't have considered it because certainly the information we were being given was that he may make a full recovery and be perfectly well enough to return back to prison, so given the fact that he had that downturn and became extremely ill in those four days we probably wouldn't have gone down the road [of submitting an application for early release on compassionate grounds].
>
> "With the man because the timescale was so short that when he did become very, very ill it was only a matter of days. So I am being absolutely honest we wouldn't have had the chance to put that paperwork together and get the medical reports because you need a medical report and they actually have to say that this guy is going to die in so many days. We wouldn't have had the timescale to put that together."

94. PSO 6000 provides details of the timescales required for making a decision:

> "A decision will usually be made within two weeks, but more quickly if the circumstances require it. If there is a medical application involving a very short life expectancy, the Early Release and Recall Section [of the Ministry of Justice] must be alerted by telephone at an early stage."

95. I understand Ms B's concerns about the timescales involved in submitting an application for early release on medical grounds. The deterioration in the man's health was sudden and significant and, from 22 January onwards, there were serious concerns that he might die imminently. However, whilst it would have been difficult to submit an application quickly, Littlehey might have contacted the Pre Release Section (as Early Release and Recall Section are now known) to seek their advice.

96. Possibly the most important aspect of an application for early release on medical grounds is the written prognosis provided by the patient's consultant. Ms B described how such a letter can take several days to

obtain. Such delays might have a significant effect on the outcome of a future application and should be addressed.

The Governor of Littlehey should seek to establish protocols with local hospitals to ensure that a written prognosis in support of applications for early release on compassionate grounds can be produced within suitable timescales.

CONCLUSION

97. After the man was first diagnosed and treated for testicular cancer in late 2006, he spent ten weeks in prison in summer 2007. During this time he told staff about his recent diagnosis and information was obtained from the hospital at which he had been treated. Nevertheless, when he was next imprisoned in November 2007, he chose not to reveal his medical history to prison staff. I am unable to say why this was.

98. Whilst the man must take significant responsibility for informing healthcare professionals of his medical history, there were several missed opportunities to obtain this information during his first days in prison in November 2007. For instance, his doctor in the community was not contacted and his old prison medical record was not called for. I make four recommendations regarding reception procedures at High Down.

99. Although diagnosed with cancer for a second time in September 2008, his prognosis was thought to be good. Sadly, his lungs became diseased as a result of side effects to his treatment and he did not recover. Littlehey cared for the man well during the time when his cancer recurred. He did not miss any chemotherapy cycles or follow up appointments. I am pleased to learn that Littlehey arranged his temporary release on licence and reduced his escort to just one officer, based outside his hospital room, when he became more seriously unwell in January 2009.

RECOMMENDATIONS

1. The head of healthcare at High Down should remind staff of the importance of fully completing the 'first reception health screen' form. She should also ensure that patients who need to see a doctor are referred appropriately by the reception nurse.

   "Accepted – first reception health screen form is now on a database and we have appointed administrators to complete the database. This is then printed, signed by the nurse as an accurate record and placed into the medical record. This is a temporary arrangement until 'TPP System One' is implemented in 2010. Any referrals required are identified by a tick box form, which is secured to the front of the medical record."

2. The head of healthcare at High Down should remind staff to request community GP records for all new arrivals in prison, especially those who report a chronic disease or other serious condition in their medical history.

   "Accepted – the reception process does include asking the prisoner to sign a consent form for obtaining information from GP's. If consent is given then the form is faxed the following working day."

3. The head of healthcare at High Down should review the means by which old medical records are filed. She should ensure that previous medical records are retrieved for all new arrivals into prison who have been in custody in the previous 12 months.

   "Accepted – High Down has a medical storage room. Older records are archived and stored by NHS Surrey, but are still retrievable. Difficulties arise when a prisoner is discharged from another establishment and because the NHS number is not the identifiable number, but with the prison number it is often very difficult to obtain previous records. However, every effort is made. This will not be a problem when all prisons have 'TPP System One'."

4. The head of healthcare at High Down should ensure that a general health assessment is offered during the first week in custody, in line with PSO 3050.

   "Accepted – general health assessment is now carried out in reception as the 'did not attend' rate for the well man clinic was unacceptably high. Extra staff have been allocated to reception to facilitate this."

   Although this recommendation has been accepted by High Down, their response does not meet the instructions of PSO 3050. As I have noted in paragraphs 80-82, a general health assessment should be offered "in the week following first reception".

5. The head of healthcare at High Down should remind doctors who work at the prison to record full details of consultations in the medical record, other than in exceptional circumstances.

   "Accepted – High Down has a clinical governance committee and carry out regular audits of medical records. Doctors do record details in medical records except where there are issues of confidentiality eg sexual health, sexually transmitted infections."

6. The head of healthcare at Littlehey should consider amending the reception health screen form to allow space for additional information about significant diseases or operations not covered elsewhere on the form.

   "Accepted – this has been completed."

7. The National Offender Management Service should consider measures to allow prisoners' access to television during inpatient stays in hospital, where the prisoner does not have private cash of their own to meet the cost.

   "Not accepted – this recommendation has been considered, however different PCTs will have different variants of access to television and radio and this will incur different costs. If a non-prisoner was in the same hospital and could not meet these then the PCT would presumably not feel obliged to do so. In light of this and the substantial potential cost, NOMS will not be able to make this a mandatory national instruction."

8. The Governor of Littlehey should seek to establish protocols with local hospitals to ensure that a written prognosis in support of applications for early release on compassionate grounds can be produced within suitable timescales.

   "Accepted – HMP Littlehey will develop protocols with their two main hospital providers to ensure that these procedures are carried out."

GOOD PRACTICE

1. The man who died was released on temporary licence shortly before his death. This allowed him to spend his final days in private with his family.