Investigation into the death of a man in January 2010 whilst in the custody of HMP High Down

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

This is the report of an investigation into the death from natural causes of a prisoner at HMP High Down who died in a hospice in January 2010.

The man had been diagnosed with widespread cancer in October 2009 and was told he had six months to live. Compassionate release was not granted by the Public Protection and Casework Section of the Ministry of Justice as the man was a foreign national prisoner who had not resided in the United Kingdom.

The man moved to a hospice on 15 January 2010 after his condition deteriorated.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my family liaison officers.

The investigation was undertaken by one of my investigators. I am grateful for the assistance he received from staff at High Down and would ask the Governor to pass on those sentiments. Two clinical reviewers were commissioned by Surrey Primary Care Trust to undertake a review of the man's clinical care and I also appreciate their assistance.

The review carried concludes that the man's clinical care was comparable to what he would have received in the community. The review found that overall the support provided by staff at High Down to the man was very good. I have noted the issues highlighted by the clinical reviewer and endorse the three recommendations in the clinical review. The recommendations concern the needs of prisoners who are physically ill, ensuring that hospital appointments are not missed and providing general nursing advice.

I have made no separate recommendations of my own.

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.

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

SUMMARY

The man was born in 1948. He was 62 years old when he died in a hospice in January 2010. He died from natural causes caused by widespread cancer.

The man had been sentenced to 15 years imprisonment at Crown Court in August 2005. After stays in HMP Wormwood Scrubs, HMP Brixton, HMP Parkhurst and HMP Coldingley, he transferred to HMP High Down on 5 September 2008.

During his first reception health screen interviews, it was recorded that the man had hypertension (high blood pressure). He was later diagnosed with prostate cancer. In October 2009, the man was informed that his prognosis was very poor and his life expectancy was six months. The man was poorly for a long time and used a wheelchair to move about the prison. He was allocated a healthcare support worker to help look after himself. Compassionate release was considered for him but, because he was a foreign national prisoner and had not resided in the United Kingdom, it was not granted.

On 19 December, the man was admitted to hospital. He was discharged from hospital on 24 December and returned to High Down. He moved to a hospice on 15 January 2010.

Whilst he was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that restraints were not to be used but that two officers were to be present at his bedside. When he moved to the hospice, the risk assessment was revised and only one officer remained on duty.

Around 1.25am on 25 January, staff at the hospice noticed that he had passed away in his sleep. They immediately informed the officer on bedwatch duty who contacted High Down.

The clinical review considered the care provided for the man. In the clinical reviewer's view, the quality of care given to him was equivalent to what he would have received in the community. The reviewer makes three recommendations which concern the needs of prisoners who are physically ill, ensuring that hospital appointments are not missed and providing general nursing advice. I understand that the prison health partnership is considering the findings from the review and developing an action plan to address them.

I make no additional recommendations of my own.

THE INVESTIGATION PROCESS

1. The investigation was opened on 1 February 2010 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event no one came forward.

2. My investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.

3. My investigator visited High Down on 5 February, including the healthcare inpatient unit, and discussed aspects of the man's treatment with staff. He returned on 19 and 20 April to carry out joint interviews with one of the clinical reviewers. They interviewed the head of healthcare, the inpatient manager, and two charge nurses. My investigator interviewed a healthcare support worker, on 23 April.

4. The Surrey Primary Care Trust commissioned a review of the man's clinical care. I am very grateful to them undertaking such a thorough review.

5. In line with my normal procedures, my investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

6. One of my family liaison officers contacted the man's family. They were able to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family were concerned about the medical care the man received whilst he was in custody. They will have the opportunity to receive my report and comment on the findings. I hope my report helps them better understand the events leading to the man's death.

HIGH DOWN

7. HMP High Down is situated near Sutton in Surrey and opened in 1992. It is a large local prison for adult and young men. (Local prisons serve magistrates and Crown Courts in their area and hold prisoners detained before trial or shortly after conviction.) At the time of the investigation, it could hold up to 1,103 prisoners.

8. There are six main house blocks (residential units). House block 3 is the induction unit. House block 6 operates as the main detoxification unit whilst house block 4 is used as an overspill detoxification unit. There is also a segregation unit and a healthcare centre. Healthcare is provided by Surrey Primary Care Trust. The healthcare centre has beds for up to 23 in-patients. However, a high proportion of the patients located on the healthcare centre have a mental illness and not a physical illness. This can result in the area being quite noisy and not conducive to someone, like the man, with a serious physical illness. Healthcare support workers also assist prisoners who had mobility problems and provide assistance with their hygiene needs.

9. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. It determines 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 also prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch is carried out by a security manager. Visits from family may be allowed and are closely monitored to ensure that they do not impinge on the security of the bedwatch.

1. The risk assessment will consider the following:

    i. The prisoner's medical condition. When there is doubt, the prison's medical officer will be asked to advise on any medical objections to the use of restraints.
    ii. Behaviour in prison.
    iii. Home circumstances.
    iv. The nature of the offence, the risk to the public and hospital staff, including the risk of hostage taking.
    v. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
    vi. The physical security of the hospital.
    vii. Assessment of visits restrictions.

2. According to the policy for performing hospital bedwatches in place when the man was in custody, the following options were available to the Governor:

i. "Escort and bedwatch with two officers or more, with restraints.
ii. Escort and bedwatch with two officers or more, without restraints.
iii. Escort and bedwatch with one officer, without restraints.
iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
v. … exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952)."

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

3. My investigator reviewed the Ombudsman's reports into earlier deaths from natural causes at High Down. He found no issues in common with the circumstances of the death of the man.

Her Majesty's Inspectorate of Prisons

4. High Down was inspected by Her Majesty's Chief Inspector of Prisons, in May 2006. In her report of that inspection, published the following August, Her Majesty's Chief Inspector of Prisons wrote:

> "High Down, along with all local prisons, is under tremendous pressure as a result of the growth in the prisoner population. Despite this, the establishment had made considerable strides in a number of areas. However, it was failing to ensure the safety of all its prisoners and we and managers had serious concerns about the behaviour and attitudes of a small number of staff. As a result, High Down is not yet the healthy prison to which its Governor aspires. Nevertheless, it is moving in the right direction."

5. The prison underwent a further, follow-up inspection in May 2009, the report of which pointed to clear evidence of improvement. In the concluding paragraph of her introduction to the report, Her Majesty's Chief Inspector of Prisons wrote:

> "In spite of its considerable expansion, High Down was a safer prison than at the time of the last inspection, thanks to considerable efforts to tackle violence and bullying. It was now performing reasonable well in all four of our key areas: safety, respect, purposeful activity and resettlement. Given the pressures of a busy and expanded local prison, this is a commendable achievement."

Independent Monitoring Board report

6. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. The Board monitors day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The latest report for High Down, for the year December 2008 to November 2009, drew attention to healthcare provision at the prison. The report said:

> "The Board believes that the impetus to maintain and improve healthcare in the prison and to promote the new initiatives, all highlighted in last year's report, has been maintained in this reporting period. … While there remain problem areas, some of which are due to budgetary constraints outside the prison's control, we consider the will is there from both the prison healthcare team and Surrey PCT (Primary Care Trust) to continue the momentum."

Performance rating

7. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS uses 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 (one being "serious concerns" and four "exceptional performance"). For the last three quarters, HMP High Down has been given a rating of three (or "good performance").

KEY EVENTS

8. The man was born in 1948 in Nigeria. He was 62 years old when he died in a hospice at 1.25am on 25 January 2010. The man died of natural causes as a consequence of widespread cancer.

9. On 15 March 2005, the man was remanded into custody by a Magistrates' Court after being charged with drug offences. He arrived at HMP Wormwood Scrubs the same day. It was his first time in prison. Prior to his arrival in custody, the man worked as an accountant and had lived in Nigeria. He was sentenced at Crown Court on in 2005 to 15 years imprisonment for drug importation. The man later moved to HMP Wandsworth, HMP Brixton, HMP Parkhurst and HMP Coldingley. He transferred to HMP High Down on 5 September 2008. During his first reception health screening interviews (prior to his arrival at High Down), it was recorded that he had hypertension (high blood pressure) and back pain.

10. He was initially categorised as a category B prisoner which was changed to category C on 28 March 2007. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt; and Category D: open conditions, prisoners who can be trusted not to try and escape.

11. On 13 June 2008, the man attended an outpatient appointment while at Coldingley for an ultrasound scan as he had been complaining about back pain and nausea. On 17 June, a prison doctor, wrote to the Urology Department at the local hospital. She wrote that the result of the ultrasound scan showed: "… normal liver, gall bladder, pancreas and spleen. … I am concerned that the pain may indeed be renal in origin, although at no stage has there been blood or protein in urine samples."

12. On 26 June, as the man was suffering from further back pain and weakness, he was taken to the Accident and Emergency (A&E) Department at the local hospital. He returned to Coldingley the same day after being prescribed pain relief. Two days later, on 28 June, the man returned to A&E as he had difficulty passing water, constipation and severe back pain. After hospital staff carried out further tests, he was diagnosed with prostate cancer with spinal cord compression.

13. He underwent a course of radiotherapy to his spine and had operations to reduce his tumour and his testosterone level. When he was discharged from hospital on 5 September, he moved to a single cell in

the healthcare centre at High Down as Coldingley did not have an inpatient facility. He used a wheelchair following his discharge from hospital.

14. On 30 April 2009, the man had an x-ray of his left hip. A locum prison doctor wrote to the man's consultant on 18 May. She noted that the result of the man's x-ray identified multiple bony lesions which were consistent with metastatic disease (cancer). The locum prison doctor wrote: "I wonder whether you feel he may require additional treatment for this."

15. When the man went to his next outpatient appointment the consultant queried why previous appointments had been missed. There was no reason recorded for the missed appointments in his records. He was found to be reasonably well and blood was taken for a Prostatic Specific Antigen (PSA, a protein produced by the prostate gland; elevated levels of PSA can be used to test for cancer) test to assess the stability of his cancer.

16. On 13 July, the man returned to hospital as he had severe back pain and increasing weakness in his legs. Investigations showed a further episode of spinal cord compression. The man underwent a course of radiotherapy and started to take steroids. His PSA was found to be raised, indicating that he had an aggressive tumour. The man was prescribed diethylstilbestrol as treatment for the cancer (diethylstilbestrol is is a man-made drug similar to the female hormone oestrogen and is used to treat advanced prostate cancer). The man developed thrombocytopenia (low platelet count) which caused haematomas (swellings containing blood) to form under his skin due to pressure. He received a platelet transfusion and the man's restraints were removed to reduce possible bleeding and pain.

17. The man was discharged from hospital on 13 August. When he was discharged, the man was unable to stand unaided and was assessed by the physiotherapist as needing a wheelchair permanently. The man also had pain in his shoulders and chest which was thought to be due to his metastatic bone disease.

18. When interviewed as part of this investigation, the healthcare support worker confirmed that he was the man's healthcare support worker. He also confirmed that he accompanied the man on some of his visits to hospital. The healthcare support worker was there to ensure that the man understood what was being explained to him by hospital staff and to feedback information discussed at consultations. The healthcare support worker confirmed that the Iman had regularly visited the man and prayed with him. The healthcare support worker also spent a lot of time with the man to assist him with his needs and ensure that he received his pain relief medication (Oramorph) when he needed it.

19. The healthcare support worker spoke positively about the actions taken by discipline staff in relation to the man. He confirmed that this enabled the man to have more time out of his cell that other prisoners on the healthcare centre. He said:

> "… in the morning we will let out the vulnerable prisoners first and then after lunch [it] will be the turn of the normal prisoners. But some of the officers … will go and open up the man's cell for us to go in and care for him, do everything and they wouldn't bother locking up until the roll (count of how many prisoners are in the prison) is in."

20. In his letter dated 12 October 2009 to the head of healthcare at High Down, a Consultant in Clinical Oncology, wrote:

> "As you know, I am treating the man … for advance prostate cancer. I last saw him when he attended my outpatient clinic on 5 October. He has very widespread secondary cancer which has seriously damaged his spinal cord, which means he is unable to walk. His cancer has always behaved aggressively and I would expect it to continue to do so. Although it is impossible to make a completely accurate prediction, I do not expect him to live longer than six months."

21. On 8 December 2009, an application for early release on compassionate grounds was forwarded to the Public Protection and Casework Section (previously know as the Early Release and Recall Section) of the Ministry of Justice. Under section 30 of the Crime (Sentences) Act 1997, the Secretary of State may, at any time, release a prisoner on licence if he or she is satisfied that exceptional circumstances exist which justify early release on compassionate grounds. Before exercising this power, the Secretary of State is required to consult the Parole Board, unless the circumstances make such a consultation impracticable.

22. The criteria for compassionate release on medical grounds are:

- The prisoner is suffering from a terminal illness and death is likely to occur very shortly. Although there are no set time limits, three months may be considered to be an appropriate period for an application to be made to the Lifer Review and Recall Section, which forms part of the National Offender Management Service.

- The risk of re-offending (particularly sexual or violent nature) is minimal.

- Further imprisonment would reduce the prisoner's life expectancy.

- There are adequate arrangements for the prisoner's care and treatment outside prison.

- Early release will bring some significant benefit to the prisoner or his or her family.

Compassionate release was not granted in this case due to the man note being
resident in the United Kingdom.

23. When interviewed as part of this investigation, the Inpatient Manager at High Down, confirmed that the prison was provided with specialised equipment for the man. It included a pressure relief mattress, sliding (glide) sheets and a hoist. She also confirmed that staff from the hospice advised on the care the man required. The Inpatient Manager said:

> "Well personally speaking I believe that I did everything I could for him. I think he received a very high standard of care in terms of day to day care and the only thing that I was disappointed about, but there was nothing I could do about, [was] arranging his compassionate discharge. Unfortunately there were other elements that affected that but in terms of the standard of care he received on the unit I believe it was high."

24. The first charge nurse told the investigator that:

> "If you wanted to ask me how could we have given him a better standard of care the answer is, within our environment, I don't think we could have done and I'd like to think, and I think you'll find that this will be a general view of some of the staff downstairs, he probably got as much care and support with us than he would have done anywhere else. Two things, why didn't he get out on compassionate leave and secondly if you can imagine someone with a grave physical illness such as this man who's going to need peace and quiet … unfortunately downstairs we can't give that, if I've got somebody who's ragingly psychotic shouting and kicking a door 24 hours a day, seven days a week."

25. The charge nurse suggested that it would have been conducive for patients like the man if High Down had a separate unit for patients who were physically ill. This was because of the high number of patients with mental illness (between 80 and 90 per cent) who are located in the healthcare centre and the associated high levels of noise.

26. The man was taken to hospital on 14 December for an outpatient appointment. He returned to High Down later that same day. The initial risk assessment was that restraints were not be used. He was also accompanied by two officers and a health care assistant.

27. On 19 December, the man was taken to the A& E Department at the local hospital. It was decided that he should be admitted and he was moved to a ward. He returned to High Down during the afternoon of 24 December, and was again returned to the healthcare centre.

28. The man moved to a hospice on 15 January 2010. His health continued to deteriorate. The initial risk assessment was that restraints were not required and one officer in plain clothes should remain on duty at his bedside (known as 'bedwatch'). A log of activities was maintained by the officers on bedwatch duty which was checked on a regular basis by a visiting duty governor.

29. In her written statement dated 25 January, a nurse at the hospice confirmed that the man passed away at 1.25am. The nurse wrote: "Verification of death – no heart sounds no respirations pupils dilated and fixed". The officer who was on bedwatch duty, contacted the prison shortly afterwards to inform the prison of the man's death.

30. Prisoners were informed of the man's death after they were unlocked on 25 January. They were also asked whether they required any support or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) All the prisoners on the Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime were reviewed. (ACCT is the Prison Service's procedure for supporting and monitoring prisoners believed to be at risk of suicide or self-harm.) When the officer on bedwatch duty returned to High Down, he was offered support from the prison's care team. The first charge nurse informed the healthcare support worker of the man's death.

31. A senior officer had already been appointed as High Down's family liaison officer. She made contact with the man's family in the United Kingdom shortly before his death (the man had daughters in the United Kingdom, although he lived in Nigeria). The family liaison officer maintained contact with the family and assisted with the funeral arrangements. High Down also offered financial assistance with the costs of the repatriation of the man's body and his funeral. The man's funeral took place on 19 March in Nigeria.

ISSUES CONSIDERED

Clinical care

32. As noted, a review of the man's medical care was undertaken by the clinical reviewer on behalf of Surrey Primary Care Trust.

33. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The medical records provide details of the personal care undertaken by healthcare staff. The records also show details of conversations between staff and the man relating to his understanding of his disease and the effects it was having on him physically, mentally, spiritually and socially. In her review the clinical reviewer wrote:

> "These notes indicate a good understanding of holistic nursing care and demonstrate actions taken to meet any problems with care. Appropriate equipment was used at all times with sensitivity being shown by using glide sheets rather than a hoist, which is important for people with spinal disease to prevent pain and further cord damage."

34. Whilst in custody the man was regularly monitored for existing heart disease and hypertension. Apart from complaining of urinary symptoms and back pain in early June 2008, there were no significant indications of prostate cancer. (In her review the clinical reviewer said that presentation with cancer in the bones is not uncommon in people living outside prison. There is some evidence that men of Afro-Caribbean origin have a higher rate of prostate cancer than white European men. The age of 60 is however at the lower end of the age range for the disease.)

35. In June 2008, during an inpatient stay in hospital, the man was investigated for the cause of his back pain and lethargy. A tumour was found on his spine and he was sent for debulking (decompressing) of the tumour. According to the clinical reviewer this is the normal treatment for people with this stage of disease. The man then had an operation to reduce the production of testosterone which was aimed at helping to control the tumour. This follows a normal plan of care as outlined in the Improving Outcome Guidance in Urological Cancer (NICE 2002). A course of radiotherapy to his spine was given during his stay in hospital and again this follows the expected course of treatment.

36. At this time the man was located at Coldingley prison which does not have an inpatient facility. Therefore he was transferred to High Down where he was cared for in a single room in the healthcare centre. Around 80 percent to 90 per cent of the prisoners in the healthcare centre suffer from mental illness rather than physical disease. According to the transcripts of interviews with staff, this can result in the area being

noisy. In order to address this, the man was cared for in another block for a short period of time but the level of nursing care available there was not adequate to meet his needs. This was recognised and the man transferred back to the 24 hour healthcare facility. The clinical reviewer recommends that alternative arrangements should be considered for the care of prisoners who are physically, rather than mentally, ill.

The Head of Prison Healthcare should consider separating prisoners who have a physical disease from those being treated for a mental illness, especially when providing end of life care.

37. There appears to be an unexplained gap in outpatient attendances between the end of 2008 and May 2009. However, when the man was next seen at hospital he was assessed as stable. This period is the only time when his care deviated from that which would have been experienced by someone living outside of prison.

The Head of Prison Healthcare should ensure that systems are developed so that hospital appointments are not missed especially when prisoners are transferred from one prison to another.

38. During July 2009, the disease escalated and the man had further radiotherapy and drug treatments in an attempt to relieve his symptoms and reduce the effects of the disease progression. The clinical reviewer states that all these would have been the usual treatment offered to other people with a similar disease.

39. The clinical reviewer was regularly visited by an Imam with whom the staff reported he had a good relationship. He was also supported by care staff and other prisoners who shared his cultural background and beliefs. There appears to have been little involvement of his family during this period but it is reported by staff that this was at the man's request.

40. Following his discharge from hospital back to the inpatient unit at High Down the man received, in the clinical reviewer's opinion, a high standard of holistic nursing care. His physical, psychological and spiritual care needs were met, at least to the standard of a person living outside hospital and in line with the supportive and palliative care guidance for adults with cancer (NICE 2004). The only exception was in the area of his social care in that he was unable to be cared for and die in his preferred place of choice, back in Africa. Staff at High Down tried to obtain his release on compassionate grounds but this was not possible.

41. The man was referred at an appropriate point to the specialist palliative care service offered by nearby hospice. This would be the usual practice for a person of this age with this complexity of disease. Staff at High Down were also able to obtain support and information on nursing

care from the Clinical Nurse Specialist from the hospice when they visited the prison.

42. In the clinical reviewer's opinion, the man had access to appropriate equipment to help with his nursing care and she commended healthcare staff for using the glide sheets rather than a hoist to move and reposition the man during the final weeks of his life. They are more suitable for people with spinal disease and spinal cord compression. This would also be normal practice for people living outside of prison.

43. The man notes that most of the staff directly involved with the man appeared to have mental health qualifications and skills and his condition required information which was outside their current roles. They sometimes relied on their previous experience before working at High Down. The clinical reviewer recommends that High Down should provide updates on treatments and therapy to help staff understand modern pathways of care.

    The Head of Prison Healthcare should provide updates on general nursing issues for all nursing staff especially where the majority have a mental health nursing training rather than a general nurse training.

44. The clinical reviewer concludes that overall the care the man received whilst in custody was comparable to what he would have received in the general community. The clinical reviewer wrote:

> "All the staff appeared motivated to provide holistic care for the man and recognised when they needed specialist advice. Evidence in the transcripts of the interviews showed that other inmates who were close to the man had received support after his death. There was also an excellent example given of sensitive support provided for a care worker who had been closely involved with the man but who had been away at the time of his death. Overall I found the support provided for the staff and the care given to the man very good."

Use of restraints

45. I am pleased to report that the risk assessment for the man was regularly reviewed and revised during his time outside High Down. When the man experienced thrombocytopaenia, a side effect of one of the drugs which causes bleeding under the skin, sensitivity was shown by the prison staff by removing restraints while the man was being treated for this condition. My investigator found that restraints were also removed when the man's condition deteriorated and he was then simply accompanied by two officers. My investigator also noted that when the man moved to the hospice he was accompanied by only one office who was in plain clothes.

46. My investigator found that the bedwatch notes were concise with legible and appropriate entries. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at High Down. The Governor may wish to share my view with managers and staff.

CONCLUSION

47. The man moved to High Down on 5 September 2008 and died from natural causes in a hospice on 25 January 2010.

48. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. The clinical reviewer has made three recommendations that I endorse. The recommendations concern the needs of prisoners who are physically ill, ensuring that hospital appointments are not missed and providing general nursing advice.

RECOMMENDATIONS

1. The Head of Prison Healthcare should consider separating prisoners who have a physical disease from those being treated for a mental illness, especially when providing end of life care.

   Partially accepted - Healthcare have 12 step-down beds, which are used for people with physical illness who need regular monitoring and more interaction with staff that can be provided on a houseblock. However it is not staffed to the same level as the in-patient unit. Therefore when patients require 24 hour high dependency care we can only provide this within our in-patient unit. We try and separate those with a mental illness by putting those individuals at one end of the ward and the physically ill at the other end. This situation is not ideal, but it is all the environment allows

2. The Head of Prison Healthcare should ensure that systems are developed so that hospital appointments are not missed especially when prisoners are transferred from one prison to another.

   Accepted - Previously High Down healthcare was totally dependent on the sending prison alerting us to the fact that someone had outstanding appointments. PPSystm One, which is being rolled out across the whole prison estate, will enable us to have more detailed information on individuals as appointment letters are scanned into the system and therefore available to the receiving prison. Appointments for individuals with cancer at High Down are not cancelled and we abide by the two week rule

3. The Head of Prison Healthcare should provide updates on general nursing issues for all nursing staff especially where the majority have a mental health nursing training rather than a general nurse training.

   Accepted - All healthcare staff in High Down have a Personal Development Plan in which they identify their learning needs. In addition regular updates on physical health are provided for all staff including Registered Mental Health Nurses. First on scene training is regularly carried out and also electrocardiogram (ECG) recording, blood pressure recording etc.