Circumstances surrounding the death of a man at Hospital while in the custody of HMP Gloucester in April 2008

Report by the Prisons and Probation Ombudsman for England and Wales

February 2009

This is the report of an investigation into the circumstances surrounding the death of a man on 22 April 2008 at Gloucester Royal Hospital. The man was a prisoner at HMP Gloucester and had been in custody for 11 months at the time of his death. In March 2008, he had been diagnosed as having lung cancer and his physical health deteriorated quickly. He was 63 years old. I would like to offer my sincere condolences to the man's family and friends for their loss.

My colleague has undertaken this investigation. I would like to thank the Governor of Gloucester and his staff for their participation. Particular thanks go to the Principal Officer for making all the practical arrangements and ensuring that documents were provided to the investigator.

The Deputy Director Clinical Development, Gloucester Primary Care Trust, was commissioned to undertake a review of the man's clinical care while in custody. Although the clinical reviewer makes a number of recommendations in her report, she concludes that the care the man received was of an acceptable and appropriate standard.

I have endorsed seven of the recommendations in the clinical review and I make a further two: one regarding healthcare and the second relating to escort procedures.

I am particularly concerned that the man was kept in restraints for as long as he was. The decisions of prison staff should reflect a balance between public protection and the compassionate management of seriously ill or dying prisoners. I repeat here a sentence I have used later in this report: Risk aversion can lead to an absence of commonsense and a lack of common humanity as a consequence.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2009**

CONTENTS

Annexes

SUMMARY

The man received an indeterminate sentence with a minimum term of six months on 21 May 2007. On his arrival at HMP Gloucester, The man underwent a medical health screening. During the screening, he was asked numerous questions but none that referred to previous illnesses. Despite this, he had the opportunity to disclose his previous medical history but chose not to do so.

In fact, four years earlier the man had suffered a serious illness (cancer of the eye) that had resulted in him having an eye removed and replaced with an artificial one. However, he had made a good recovery following treatment and had been generally fit and well before he came into custody.

The man was considered an exemplary prisoner who enjoyed keeping fit. He would regularly attend the gymnasium or run laps of the exercise yard. However, shortly after Christmas 2007 he began to exercise less. He had developed a persistent cough and was getting breathless following any exercise. In February 2008, he submitted an application to healthcare and was referred to the doctor.

The prison doctor saw the man on 12 February 2008 and, following an examination, he asked a nurse to assess the man in her capacity as lead asthma nurse. The prison doctor also made a routine referral for the man to have a chest x-ray at Gloucester Royal Hospital (GRH). During the nurse's assessment, she asked the man again about his past medical history but once more he did not to mention his previous cancer. Following the assessment, the man was diagnosed as having asthma and provided with inhalers to alleviate his breathing.

The man attended the hospital on 25 February for his chest x-ray. The results highlighted a mass in the man's right lung, so a referral under the NHS 'two-week rule' for cancer patients was made to a chest specialist. The man remained positive but his condition deteriorated and he lost weight as he was unable to digest solid food. Both staff and fellow prisoners noticed this and were concerned for his well-being. The healthcare department prescribed supplement drinks but later he also found these difficult to keep down.

The nurse spoke with the man again on 28 February and he disclosed the information about his previous cancer. With his approval, the nurse contacted his previous doctor for his notes which were faxed to her the same afternoon. When seen by the chest specialist on 6 March at GRH, the man was told that, in view of his previous cancer, the most likely diagnosis would be a malignant melanoma but a Computed Tomography (CT) scan would be required. (This is a process which uses multiple x-ray images to reveal soft tissue structures that cannot be seen by conventional radiography.) Despite this news, the man remained positive although he was finding it more difficult to eat and breathing was becoming harder.

The scan was carried out on 19 March, and it showed that the man had major intrapulmonary and mediostinal disease (lung cancer). Over the next few weeks, the man continued to deteriorate but he remained located on the residential wing. However, members of staff raised concerns on 31 March and he was subsequently admitted to the healthcare department on 1 April.

Over the next week, the man remained in healthcare and was monitored closely by staff. On 8 April, a healthcare assistant asked the nurse to see the man as they were concerned about his breathing. The doctor and the Head of Healthcare also saw him and thought that he should be admitted to GRH. After discussion with the hospital, the man was transferred by ambulance.

The man had a chest drain inserted shortly arriving at the hospital and his breathing appeared to improve but he remained very ill. Following a discussion with the consultant, the man was moved to Cheltenham Hospital on 10 April in order to have a course of radiotherapy. His condition deteriorated slightly following his first course of treatment and the man discussed with the doctor his wishes should he go into cardiac arrest. He expressed a wish not to be resuscitated. While in hospital, the man was visited by both his former wife and his daughter. Due to his deteriorating condition, the prison took the decision to remove all restraints from the man although the escort officers remained.

On 16 April, a governor informed the head of healthcare that the hospital had confirmed that the man's life expectancy was about two weeks and he would now be receiving palliative care. Because of this, he was moved back to GRH on 17 April. The man condition continued to deteriorate over the next few days and he became more and more confused by his situation. This resulted in him refusing both food and treatment. However, medical staff persuaded him that this was not in his best interests. The man's family visited frequently.

Five days later, on 21 April 2008, a member of the prison's escort staff alerted nurses as they believed that the man had passed away. On examination, the nurses concluded that he had died and the duty sister confirmed this at 12.25pm. His family were at his bedside.

Following the man's death, the prison maintained contact with his family and offered to pay the funeral expenses. Staff subsequently arranged for his family to visit the prison and his remaining property and money were returned during the course of the visit.

THE INVESTIGATION PROCESS

1. My investigator obtained the man's prison and medical records. Following initial contact with the Deputy Governor, on 24 April, the investigation was formally opened on 30 April when the investigator visited HMP Gloucester and met the Principal Officer who was to act as the liaison officer. The investigator spoke to four members of staff during the investigation. The notes from the interviews are attached as annexes to my report.

2. Prior to the investigator making his initial visit to Gloucester, notices informing both staff and prisoners about the investigation were issued. The notices also invited anyone with relevant information to contact the investigator. In response to the notices, three prisoners contacted the investigator by letter. They all had concerns regarding the healthcare afforded to the man. My investigator attempted to speak with two of the prisoners who had contacted him but at the time he visited Gloucester they had been transferred. Nevertheless, the issues they raised in their letters have been thoroughly investigated.

3. One of my Family Liaison Officers (FLOs) attempted to telephone the man's former wife on 16 May, but was unable to get through on the number given. In view of this, my family liaison officer sent a letter asking the man's ex-wife to contact her about the investigation. My family liaison officer received a reply from the man's former wife on 28 May that gave new contact details and informed my family liaison officer that the family had no concerns. My family liaison officer tried a further ten times to make contact on the new number provided but was unable to make contact. My family liaison officer sent a further letter on 11 July, informing the man's ex- wife that she had received her letter and she understood that the family had no issues to raise. My family liaison officer also informed the man's ex-wife that she would be in touch again when the draft report was ready.

4. HM Coroner was informed of the investigation and a copy of this report will be sent to assist with his enquiries. The Coroner has sensibly regarded the man's death from metastatic melanoma as entirely natural. In accordance with the pre-existing diagnosis of terminal cancer, the Coroner waived the requirement to hold a post mortem examination.

HMP GLOUCESTER

5. HMP Gloucester is situated on an inner-city site and has partial 'listed building' status. It is a category B establishment for adult male prisoners, intended to hold mainly those remanded or recently convicted. Young offenders aged from 18 to 20 are also accommodated, but there is no separate wing. The certified normal accommodation for the establishment is 236 but it has an operational capacity (maximum crowded capacity) of 330. The prison serves the Crown Courts of Gloucester and Hereford, together with the associated Magistrates' Courts. However, it is normal for prisoners to come from a far wider area.

6. HM Chief Inspector of Prisons, Ms Anne Owers, carried out an announced inspection of HMP Gloucester in 2007. In her report, Ms Owers says of the healthcare at Gloucester:

> "Gloucestershire Primary Care Trust (PCT) was responsible for commissioning health services and was currently reviewing services following its restructuring under recent NHS changes … The prison partnership board met regularly, and there was evidence that the PCT-prison partnership relationship worked well.
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> "There were treatment rooms on all the wings, but these were generally basic and worn, and storage facilities varied. All prisoners other than inpatients received their medication from these treatment rooms, which had gated hatches through which medicines were supplied. The hatches gave no opportunity for private conversation or counselling. There was a healthcare room in the reception area, which was fit for purpose.
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> "A local GP surgery provided 24-hour medical cover to the prison, which ensured a high level of continuity of care. A rota of six GPs covered the prison from 9.30am until 3.30pm Monday to Friday, and from 9.30am until 11.30am on Saturdays. Staff felt well supported by the GPs. A nurse saw all new arrivals in the reception medical room. Most prisoners arrived from court and were given an initial health screen to assess their immediate medical needs. Those with an identified medical need, or who requested to do so, saw the doctor within 24 hours for further examination.
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> "Secondary screening was usually completed within three days. Prisoners who wanted to see the doctor completed an application form and posted it in dedicated healthcare boxes on the wing. These were emptied daily by a nurse who ran the department. Alternatively, wing nurses undertook limited health assessments during medication times. All prisoners who went to the healthcare department were collected from and returned to the wings by the healthcare discipline officer. This was a very efficient system and prevented time wasting for both prisoners and healthcare staff. The officer was efficient and had developed sound methods to ensure that prisoners arrived on time for appointments, and also limited the numbers who did not attend for appointments. An HCA (healthcare assistant)

assigned to the GP clinics also helped the process to run smoothly, with patients seen on time and no delay in carrying out the doctor's instructions.

"There was only limited chronic disease management in place. Although prisoners with long-term illnesses were identified in reception and their names placed on a register, there was no automatic follow-up. There was a special sick system whereby prisoners who felt unwell could report sick through their wing officer who rang healthcare to arrange for the prisoner to be seen.

"The administrators arranged external NHS appointments, and up to two prisoners a day could visit local hospitals. A variety of local hospitals were used and administrators had built up good working relationships with them; they often had to 'juggle' appointments to ensure that prisoners attended. In the final quarter of 2006, only two out of 60 appointments were cancelled due to escort staff shortages."

7. The Independent Monitoring Board (IMB) at Gloucester published an annual report in 2007. The IMB concluded that:

"HMP Gloucester is run efficiently by a dedicated staff. The prison has benefited from a sustained period of improvement under one governor and this has been maintained in a smooth transition to a new governor in the second half of the year. In most of the statistical analyses carried out this year by HM Chief Inspector of Prisons, HMP Gloucester performed well above the average of comparable establishments. Staff/prisoner relations are generally good, and the Board has been pleased to note that Black and Minority Ethnic (BME) prisoners give a positive response to questions about their treatment. HMP Gloucester has been deemed the 'most improved' prison and has achieved level 4 ranking as one of the best in the country. Although high professional standards among most staff mean that, at a personal level, prisoners are in large part treated with humanity and dignity, the failure of the system to provide appropriate facilities demeans prisoners and staff alike, and wastes opportunities that prison can potentially provide for reformation and rehabilitation. Despite the considerable financial investment in HMP Gloucester, a consistent lack of funding for crucial maintenance and improvements limits and frustrates the efforts of prison management and staff. It thereby fails also to provide the public with value for their money."

8. Since my office took over responsibility in 2004 for investigating all deaths in custody, there had been six deaths at Gloucester prior to that of the man. Four of these were apparently self inflicted with the others attributed to natural causes. I have previously made various recommendations relating to healthcare – in particular, to record keeping – and this is mirrored in this report.

KEY FINDINGS

Initial time in custody

9. The man was given an indeterminate sentence on 21 May 2007. He had a minimum time to serve of six months. Prisoners with indeterminate sentences are treated akin to life sentenced prisoners in respect of their licence conditions and are subject to the parole procedures. This meant that the man would have to satisfy the Parole Board that he had successfully addressed his offending behaviour and reduced his risk of reoffending before he could be granted release on licence.

10. On his arrival into custody, the man indicated that he was fit and well with no medical concerns. The nurse who conducted the initial health screen went through the process using the standard assessment form. The prisoner is asked routine questions regarding previous self-harm, mental health issues or ongoing chronic illnesses such as asthma. The man responded to all the questions put to him and no medical concerns were reported.

11. However, in 2004 the man had in fact been diagnosed with chorodial melanoma (eye cancer). This resulted in his left eye being removed and replaced with an artificial one. The man recovered and his prognosis was very good. The questioning during the health screen made no reference to past medical procedures and, for reasons that could not be established during my investigation, the man did not choose to disclose this information.

12. Following the health screen, the man was located to the vulnerable prisoner (VP) wing due to the nature of his offences. As he had been in custody previously, he settled quickly into the regime. He was considered by staff on his wing to be a model prisoner and, during the investigation, an officer said that he would have liked an entire wing of prisoners like the man.

13. Between 22 July and 18 August 2007, the man was temporarily moved to HMP Blakenhurst. This was due to flooding in Gloucestershire. His time at Blakenhurst was uneventful and he returned to Gloucester once the problems had been rectified.

14. The man was considered by staff and prisoners to be a fit person who attended the gymnasium on a regular basis. His wing officers commented that, when it was not possible to go to the gym, he would often run around the exercise yard during recreation periods instead. He had won a wing competition over the Christmas period of 2007 for the most ‘chin ups’ in the gymnasium. He indicated a willingness to address his offending behaviour and had begun to attend a course before coming into custody. Once in custody he was allocated to attend education which he did on a regular basis.

Events from February to 1 April 2008

15. Although the man was enthusiastic about keeping fit, after Christmas 2007 he attended both the gymnasium and exercise periods less frequently. This was confirmed to the investigator by wing staff and prisoners who knew the man.

16. The man did not have any significant contact with healthcare until 12 February 2008, when he was assessed by the prison doctor as an urgent referral from the nurse. The nurse had seen the man a few days earlier after he had submitted an application complaining of a troublesome night time cough and exercise induced breathlessness.

17. Following the appointment, the prison doctor asked the nurse, in her capacity as the asthma lead nurse, to see the man and conduct the necessary tests in her clinic. Due to the man's age, the prison doctor also referred him for a chest x-ray at Gloucester Royal Hospital (GRH). The following day, the nurse saw the man on his wing to carry out the tests and she also discussed with him his past medical history to ascertain any underlying cause for his symptoms. The man told the nurse that he was a non-smoker and had not been exposed to secondary smoke as a child. He said that his cough had developed shortly after Christmas and had caused him to cut down on his exercise due to breathlessness. However, he did not at this time disclose any other past medical problems.

18. After the nurse had discussed the man's test results with a second prison doctor, she diagnosed him as having asthma. He was provided with information about the condition and given an inhaler. The man initially struggled with the inhaler, so the nurse provided him with additional equipment to make it easier to use and arranged to see him again to check on his progress.

19. On the morning of 25 February 2008, the man attended the treatment hatch to collect his medication. He spoke to a second nurse and told her that he was troubled by the breathlessness and felt that it was not improving despite the use of the inhalers. The second nurse arranged to check the man inhaling technique that afternoon as the asthma nurse was not on duty. She gave him an appointment for the doctor on 27 February.

20. However, the man went to GRH on the afternoon of 25 February for his routine chest x-ray. This highlighted a mass in his right lung. In order to rule out malignancy, a referral to a chest specialist was recommended under the National Health Service two-week rule for suspected cancer. (The two-week rule was introduced by the NHS to ensure that patients with suspected cancer would be seen within 14 days of being referred by their general practitioner.) The results were faxed to the prison healthcare department. On receipt of the results a third prison doctor, faxed an urgent referral form to GRH on 26 February as recommended.

21. The man remained positive but was beginning to have difficulty in eating solid foods and found it increasingly difficult to digest his meals. As a result, he was seen by one of the prison doctors on 27 February who prescribed both a linctus for his continuing cough, and a supplement drink called Ensure Plus which initially had to be taken in sight of a nurse. The doctor also discussed the x-ray results and, at the man's request, the possible diagnoses.

22. The nurse saw the man the following day, again in her capacity as the asthma nurse. The nurse recorded in the medical record that the man was unable to talk in full sentences due to his shortness of breath, and that he felt the asthma medication had not been beneficial. Because of this the second prison doctor prescribed a five-day course of prednisolone to assist his breathing.

23. The same day, during a talk with the nurse in his cell, the man disclosed that his left eye had been removed several years earlier due to cancer. In light of this information, the nurse requested permission to contact his previous doctor who, the same afternoon, supplied information relating to the man's previous cancer treatment.

24. A hospital doctor of the Thoracic Medicine Department at GRH saw the man on 6 March. During the appointment, the man said he had no chest pain or other symptoms, apart from loss of appetite and some weight loss. The doctor noted his previous cancer treatment and informed the man that the most likely diagnosis would be metastatic melanoma, although he would need a CT scan before this could be confirmed.

25. On his return from GRH, the man asked to speak with the nurse. He told her of the possible cancer diagnosis and spoke about his thoughts and his family. He also told the nurse that the doctor from the hospital had spoken about a CT scan. The nurse asked one of the administrative assistants in healthcare to contact the hospital. The healthcare department called the hospital on numerous occasions over the next month to enquire about the appointment.

26. The man continued to be polite and respectful and did not complain, despite the uncertainty about his health. He suffered from nausea and loss of appetite. It was evident during the investigation, from speaking to both staff and prisoners, that the man's weight loss was visible. Prisoners mentioned in letters to the investigator their concern that not enough was being done for the man and that he was being ignored. However, my investigator found no evidence to support these claims.

27. On 19 March, the man attended GRH for a CT scan. He remained on the wing but his weight loss was becoming increasingly evident. He even experienced difficulty digesting the Ensure that had been prescribed as a nutritional supplement. The second nurse saw him at the treatment hatch on 22 March. The man felt that the paracetomol he had been taking was not having as good an effect on his cough as co-codamol. He told the nurse that he generally felt unwell and had been vomiting the Ensure. The second nurse

spoke to a doctor who prescribed additional co-codamol and anti-sickness medication.

28. The following day, the second nurse saw the man again while on the wing during breakfast and commented in his medical record that he looked brighter. The man said that he had a better night's sleep. Although still breathless, he appeared to be talking comfortably and confirmed that he felt the inhaler had been effective. The nurse checked on him mid-morning and the man told her that he had not managed to keep down his Ensure. He did manage to keep down the lunchtime dose of Ensure but had no other food. The second nurse made a note that it might be possible to obtain high protein yoghurts for the man.

29. The doctor at GRH sent a letter to the prison on 25 March, informing them of the results of the man's CT scan. As expected, the CT scan showed that he had major intrapulmonary and mediostinal disease (lung cancer).

30. A prison officer, who was a regular member of staff on the man's wing, was on a week's leave at the end of March and returned to duty on 31 March. The officer told the investigator that, on his return, he could clearly see a decline in the man's health. His concern prompted the officer to go and see the man in his cell to enquire about his well-being, particularly as the man was someone who would not complain unnecessarily. The man explained that he had been vomiting more and was even unable to keep down water.

31. Other staff on the wing shared the officer's concerns about the man. He therefore contacted the healthcare wing and spoke with healthcare assistant. The officer informed the healthcare assistant that, in his opinion, the man needed to be located in the healthcare centre immediately, or at least be seen by a doctor. The healthcare assistant explained that, at the time, there were no doctors in the establishment but the man would be seen the following morning.

32. The officer contacted the healthcare centre first thing in the morning. He was told to take the man across to the centre and the man was subsequently admitted. The officer was keen to stress to the investigator that the man had not asked him to contact healthcare and it was staff concern that prompted it. He also said that he was unaware of any occasion when the man had asked to be seen by healthcare and had been refused or not seen.

1 April to 21 April

33. The doctor saw the man when he arrived in the healthcare centre. He was then monitored throughout the afternoon. The man declined his lunch meal but agreed to try some Ensure later on. He remained in his cell with the door open during the afternoon and appeared breathless at times. Although only given soup for his evening meal, he was unable to digest it and had been vomiting on and off during the afternoon. However, he settled down and appeared to have a restful night.

34. The following day, healthcare staff reviewed the man's condition and discussed his diagnosis with him, including the information that his illness was likely to be associated with his earlier cancer. During the review, he was not able to speak in full sentences due to the breathlessness. The man was informed that, because of his earlier CT scan, a biopsy had been arranged for 4 April. His situation was discussed with the deputy governor who was told that the man's condition was likely to be incurable and any treatment was likely to be palliative. During the remainder of the day, the man remained on his bed. His breathing remained the same but he again managed to have a restful night.

35. Over the next few days, the man's condition remained the same and he spent much of his time in cell, apart from attending an appointment at GRH on 4 April for a biopsy. He found it increasingly difficult to keep anything down and began to refuse solid food. Nursing staff continued to encourage him to take fluids but he found this difficult at times. At night, the man appeared to be more settled and would sleep quite well when not disturbed by his cough.

36. On 8 April, the nurse was in charge of the assessment unit where the man was a patient. At 11.35am, she was asked by a HCA to assess the man, as there were concerns over his breathing. The nurse saw him straight away and, after applying oxygen, requested a doctor to see him immediately. The man said that he felt better when the oxygen was applied. He continued to be given the oxygen and monitored over the afternoon, but there were still concerns about his breathing and blood pressure. The nurse consulted the head of healthcare and the doctor about her concerns.

37. The head of healthcare told the investigator that she had been on leave prior to the man moving to the healthcare centre. She was therefore surprised by his deterioration and immediately thought that he would be better placed in an outside hospital. After discussion with the hospital doctor's secretary at GRH, the healthcare team were advised to admit the man to the hospital's emergency department

38. Two members of staff escorted the man to GRH at 3.45pm. A chest drain was inserted and a doctor informed the escort staff that the man was likely to remain there overnight. At about 11.20pm, he was taken for an x-ray to confirm the drain was working. The escort staff recorded that the man's breathing had improved since arrival at hospital. At the time, the man was handcuffed but it is understood that, once he was in the ward, the restraint was reduced to an escort chain. (An escort chain is a single cuff attached to the prisoner's wrist and joined to another single cuff attached to an officer by a length of chain. This allows more freedom of movement while still keeping the prisoner secure.)

39. The following morning, the man was seen by a consultant who told him that the result of tests should be known on 10 April. The consultant also said that the man would not be discharged until at least after the weekend. The man received a telephone call from his former wife during the afternoon and remained comfortable for the remainder of the day.

40. On 10 April, prison healthcare staff contacted the hospital for an update on the man's condition and were informed that he was 'up and about' and had been eating and drinking. They were also told that a chest drain had been fitted. Later that morning a doctor discussed possible treatments with the man. It was explained that they would mean a transfer to Cheltenham General Hospital (CGH) that was likely to take place later that afternoon. The doctor also the man of his possible life expectancy. This seemed to come as a shock to him.

41. At 4.20pm the same afternoon, the man was moved to another ward at CGH as arranged. A doctor saw him on arrival and informed him that he would start radiotherapy the following day. It would last for around five days. The doctor explained to the prison escort staff that he would need to speak with the healthcare department at the prison as the seriousness of the man's condition and treatment would affect his mobility. The escort staff contacted the prison to update them on the man's condition. They asked the prison to contact his former wife to let her know the telephone number in his room.

42. The following afternoon, escort staff contacted the prison to ask permission for the restraints to be removed for the duration of the man's radiotherapy. This was granted. The treatment lasted for about one hour and, on his return to the ward, the restraints were re-applied. Following his first treatment, the man was given anti-sickness medication but, apart from that, he appeared well. He received a visit from his daughter in the evening and it was confirmed that she would visit again at the weekend with his ex-wife.

43. During the late afternoon on 12 April, the man had difficulty breathing so nursing staff administered oxygen. Escort staff were told that the hospital was likely to invite the man's family for a visit at short notice as his prognosis was not considered to be good. The escort staff passed the information to the prison, and at 5.10pm a governor went to the hospital. The governor had already notified the man's family of his condition and advised them that the hospital recommended visiting. The governor also authorised the removal of all restraints.

44. A doctor visited the man at 6.15pm and explained to him that the reason for his discomfort was increased fluid on his lungs. The doctor asked the man whether he wanted to be resuscitated in the event that his heart stopped. The man asked about the consequences of resuscitation and, once the doctor explained, he confirmed that he did not wish to be resuscitated. The doctor carried out a further chest drain at 7.00pm. Following his talk with the doctor, the man became tearful and the doctor asked the escort staff to let medical staff know if he wished to speak with anyone further.

45. Despite the earlier fears, the man's condition improved slightly. He remained unrestrained. The bedwatch log indicates that the following day he appeared to be a little better than the previous evening. He also received a visit from his family. The prison healthcare department contacted the hospital again on 14 April to enquire about his condition and the senior nurse on duty said that the

man was doing well. The chest drain remained in place and was working well. He was due to be reviewed later that day in relation to his radiotherapy.

46. Later that afternoon, the head of healthcare spoke to a doctor at CGH to find out who she needed to contact in order to get a report on the man's diagnosis/prognosis. The report was required to enable the prison to submit an application for compassionate release. The doctor explained that they were still awaiting the outcome of tests and whether or not the man was going to accept the treatment plan. The consultant responsible was not on duty but the doctor said that he would try to update the prison later in the day.

47. At 2.00pm, another governor, who had been in touch with the consultant at CGH, updated the head of healthcare. The man's prognosis was considered to be about two weeks. He had decided to cease all treatment other than end of life palliative care. The head of healthcare confirmed this with the doctor at CGH and requested a report to this effect in writing.

48. The man's condition remained stable and, apart from attending the radiology department to complete his course of radiotherapy, he spent his time in his room on the ward chatting with the escort staff. On 16 April, the forms requesting his release from prison on compassionate grounds were completed and plans were made for him to go to a terminal care bed at GRH in the absence of a hospice place.

49. The man arrived back at GRH at 5.10pm on 17 April. Shortly after his arrival, he became confused as to where he was and what was wrong with him. His confusion continued and he began to refuse treatment, despite nursing staff advising him of the risks. During the evening, he remained restless and continued to refuse his treatment, believing that it was not doing him any good.

50. Over the next few days, the man continued at times to be confused by his situation and his breathing difficulties caused him to be very restless. However, he remained talkative with the escort staff and received visits from his family. Nursing staff monitored him regularly and he was placed on a nebuliser to help his breathing.

51. On 21 April, the man's condition deteriorated further. His former wife and daughter remained at the hospital with him because it was felt he did not have long to live. The ward sister asked the escort staff whether the man could be released on licence in view of his condition but was told a decision was still awaited.

52. At 11.40pm, an officer told nursing staff that the man appeared to have passed away. Nurses attended and were also of the opinion that he had died but said this would need to be confirmed. His family were with him at this time. A Sister confirmed the man's death at 12.25pm.

Events following the man's death

53. The deputy governor attended GRH following the man's death and spoke with the family. He discussed their immediate concerns and arranged for further contact. The prison's Family Liaison Officer was appointed on 22 April.

54. The prison's family liaison officer contacted the man's ex-wife on 22 April and explained her role. The family said that they were due to move house and asked the liaison officer if she could retain any property belonging to the man until after this had taken place. The liaison officer agreed to this. She provided the family with her contact details and subsequently arranged for the property to be checked and for any money belonging to the man to be obtained. The man's former wife said that she was grateful for the support.

55. On 29 April, the prison's family liaison officer contacted the man's daughter who confirmed that the family did not want any prison representatives to attend the funeral and provided an address where the man's property should be sent. In addition, the man's daughter asked if the prison's family liaison officer could find out from the man's property any information relating to a music track that he wished to be played at his funeral. The liaison officer obtained this information and contacted the man's daughter later that day. On behalf of the Governor, she also offered to pay the costs of the funeral.

56. The prison's family liaison officer next contacted the man's daughter on 2 June to ask whether the family would like to visit the prison to meet with her and the Governor. The liaison officer explained that both she and the Governor were due to go on leave but visiting arrangements could be made for their return.

57. The man's ex-wife and his daughter visited the prison on 11 July and met the prison's family liaison officer and the Governor. During the visit, the man's remaining property and money were handed over. The family were complimentary regarding the care that the man had received. However, they had some concerns about his location in the later stages of his illness, feeling that it would have been more appropriate for him to have been in a hospice. While I share their views, it was apparent from the documentation that, although a hospice would have been more desirable, the man's condition had deteriorated so quickly that there was no time to arrange it.

ISSUES

Reception health screening

58. When the man was received into custody, a member of the healthcare team conducted a full health screen. The health screening at Gloucester follows that used across the Prison Service. The questions asked during the process focus heavily on self-harm issues and current illnesses, with little mention of past medical history other than mental health. It is therefore left to the individual to choose whether to disclose information about their previous medical history that might prove beneficial at a later stage. My investigator was told that staff do not routinely seek a prisoner's previous medical notes, regardless of their sentence.

59. The clinical reviewer refers to the fact that the man's artificial eye had not been observed by the nurse conducting the screening which might have led to further questioning. However, a number of staff who dealt with the man daily were also unaware that he had an artificial eye until told by my investigator. Nevertheless, it is essential for staff conducting medical screening to ask for permission to obtain information on a prisoner's previous medical history, if such information is required. The clinical reviewer has made the following recommendations in respect of the screening process, which I endorse:

The Head of Healthcare should consider updating the training on reception interview skills to assist staff with ascertaining crucial previous medical history and observing the patient.

Following the publication of the draft report, the prison accepted this recommendation and said:

'This has been added to the Local Induction as a competency based training need. All staff have to be trained based on their own needs, i.e. 2 x shadow of senior nurse, 2 x lead with senior nurse, 2 x review with senior nurse.'

The Head of Healthcare should consider the relevance and importance of obtaining previous clinical records for prisoners, particularly when a life sentence is given.

Following the publication of the draft report, the prison accepted this recommendation and said:

'Prompts have been added to the Secondary Screening Tools'

Record keeping

60. Both my investigator and the clinical reviewer found the medical notes that were available to be mostly comprehensive. However, notes were only available from 25 February onwards. The notes of the man's earlier healthcare contact regarding his asthma had been mislaid and, despite requests by the clinical reviewer, could not be found. In her report, the clinical

reviewer says that access to this information might have proved beneficial to healthcare staff.

61. The clinical reviewer also mentions the need to remind healthcare staff of the requirement to print as well as sign their names in the medical records. She said that, in most cases, it had not been possible to identify who had made the entries from their signatures. The reviewer acknowledges that steps have been taken to provide stamps for healthcare staff to use when making entries in medical records, which should serve to remind staff to sign and print. The clinical reviewer also says that occasionally dates and times or place of establishment were missing.

62. My investigator also found that healthcare staff neglected to use the appropriate part of the documentation to record relevant events relating to a prisoner's health. When the man returned from hospital, a member of the healthcare team should have recorded any changes to his circumstances on the relevant document inside his medical record. Although he was seen on return, the relevant information was recorded in the body of his record so would not be quickly identified by a member of staff reading it. The head of healthcare informed my investigator that staff should be recording these events in the correct place. She provided the investigator with a copy of the protocol for receiving new and returning prisoners into Gloucester. The clinical reviewer also says that, when the man was transferred, there was little information about the drugs he was taking.

63. The clinical reviewer concludes her findings on record keeping by saying that they record problems as they arose and the action taken to rectify them. She further says that the clinical records provided clear evidence of the care planned and the decisions made. However, improvements could be made to the nursing care plan and needs assessment. The clinical reviewer considers that a trained nurse should countersign entries or care plans made by a healthcare assistant.

64. Improvements to medical record keeping are amongst the most frequent recommendations in my reports. I have made previous similar recommendations in relation to HMP Gloucester and I am disappointed to have to do so again in this case:

The Head of Healthcare should ensure that the Protocol for Receiving New and Returning Prisoners into HMP Gloucester is updated to instruct staff of the correct place to record additional information.

Following the publication of the draft report the prison accepted this recommendation and said:

'Reminders have been issued at staff meetings in September and October.'

In addition, the clinical reviewer makes two recommendations about record keeping, which I endorse and amplify:

The Head of Healthcare should consider updating training and guidance for all healthcare staff in relation to record keeping. In particular, they should be reminded of their obligations to comply with the guidelines regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

Following the publication of the draft report, the prison accepted this recommendation and said:

'The Head of Healthcare has gone to staff meetings in September and October.'

'The Head of Healthcare has issued a memo re NMC code of conduct and page 8 which refers directly to written entries.'

'Training from external PCT member regarding written entries will be arranged for December 2008.'

The Head of Healthcare should consider improving transfer information in relation to clinical issues.

Following the publication of the draft report, the prison accepted this recommendation and said:

'An appropriate Team Leader will be allocated to complex cases when in other outside hospital units.'

'Written discharge summaries will be completed when transferring patients between establishments and other outside hospitals.'

Access to healthcare/medication

65. The man was unable to manage solid food as his illness progressed and, later on, he was even unable to keep down water. This continued for some weeks prior to his admission on 1 April to the healthcare centre. Medical staff were aware that he was not eating, but they did not record his daily fluid intake or monitor his weight loss. During an interview with my investigator, the head of healthcare agreed that monitoring of the man's food and fluid intake, as well as his weight, should have been put in place. Given that the head of healthcare is already aware that monitoring should have been carried out and has reminded her staff of its importance, I make no recommendation here.

66. The man had to take his food supplement in sight of healthcare staff, which meant that he had to drink the carton while standing at the treatment hatch. Given that the man was finding it increasingly difficult to keep water down, I question whether it was reasonable to expect him to drink an entire nutrient supplement in a short space of time. It is therefore unsurprising that, at times, he choose not to take it or, when he managed to do so, he then vomited on his return to his cell.

67. The head of healthcare was asked why The man had to take the Ensure at the hatch. She said that it was supervised because some prisoners had used it to make illicit alcohol. However, The head of healthcare said that The man had subsequently been given permission to take his supplement to his cell. I acknowledge that changes were made to allow The man to take his supplement as required and I make no further recommendations on this aspect of his care.

End of life care

68. The treatment afforded to the man at Gloucester, while considered to be of an acceptable and appropriate standard, failed to provide the necessary end of life care. The clinical reviewer advises that, in the future, the prison should draw up a comprehensive care plan to include detailed plans for nutritional/fluid support and replacement, symptom control and emotional care. She further advises that a referral to the end of life team should be made at an early stage as soon as a diagnosis and prognosis is confirmed. She adds:

> "The PCT operates a Gold Standard Framework (GSF) in relation to palliative care and this was not implemented for the man. GSF is a systematic evidence based approach to optimising the care for patients nearing the end of life, and to develop a locally based system to improve and optimise the organisation and quality of care for patients and their carers in the last year of life."

The clinical reviewer makes two recommendations in relation to this issue which I endorse:

Care of prisoners at the end of life should be included as part of the local Primary Care Trust Gold Standard Framework development work.

Following the publication of the draft report the prison accepted this recommendation and said:

'Have met with the Gloucester Primary Care Trust Lead, who is happy to do some work with HMP Gloucester.'

'Members of the Community Team are coming to visit to discuss the needs of the team.'

A protocol should be agreed with local palliative care specialists including triggers for referral and access to specialist advice and support, liaison with friends and relatives and communication with other parties/agencies within and outside the prison.

Following the publication of the draft report the prison accepted this recommendation and said:

'Staff have attended a local conference on end of life care on 10 October 2008.'

'Once members of the Community Team have visited, needs will be looked at and a protocol developed by March 2009.'

Escort to hospital

69. Gloucester prison operates a system in which a maximum of two escorts per day are provided for prisoners attending outpatient appointments at outside hospital. The escorts may also be used for reasons other than hospital appointments, but the threshold remains a maximum of two. In the man's case, his CT scan was delayed as the limit on the number of escorts had already been reached. The clinical reviewer says in her report, "this is not considered a contributory factor in this case, but is of note and considering the nature of a referral of this type may be significant in other cases". The clinical reviewer makes one recommendation on this issue which I have expanded:

The Head of Healthcare should instruct staff to make every effort to avoid cancelling important investigations, particularly those related to urgent medical care. Consideration should also be given to making alternative escort arrangements in exceptional circumstances.

Following the publication of the draft report the prison accepted this recommendation and said:

'Staff have always had discussion around priorities i.e. emergency cases overriding routine cases.'

'Male nursing staff who are C&R trained are used as the third escort on occasions that the prison cannot provide the third escort.'

70. The clinical reviewer is concerned that there appeared to be few resources available to staff who were distressed by escorting sick/dying prisoners on either appointments or bed watches. However, my investigator was satisfied that the prison has adequate provision for staff support in place, and that staff felt confident to access it should they feel the need. In view of this, I make no recommendation on this point.

71. When the man was admitted to hospital, he remained in restraints for the first four days and they were not removed until his condition deteriorated further. I acknowledge that the level of restraint used was kept to the minimum and this allowed the man to move around and give medical staff better access. However, I question the necessity for any restraints to be used at all. The man was clearly extremely unwell before he was admitted to hospital. It seems to me extremely unlikely that he had the inclination or desire to escape from custody. I understand that these are issues that have to be considered by the prison when making such decisions. However, it is also important for the prison to ensure that there is a balance between public protection and the compassionate management of seriously ill or dying prisoners. Risk aversion can lead to an absence of commonsense and a lack of common humanity as a consequence.

72. I have addressed these matters in previous reports. Following my previous recommendations, the Prison Service conducted a review of the use of restraints during hospital escorts and bedwatches. As a consequence, the guidance has been amended to take account of prisoners who are seriously or terminally ill. The revised guidance was issued to all Governors during February 2008. In view of this, I make the following recommendation:

The Governor should ensure that the local security procedures relating to escorts and bedwatches are updated to reflect the revised national guidance issued in February 2008 relating to seriously ill or dying prisoners.

Following publication of the draft report the prison accepted this recommendation and said:

'The Bedwatch management checklist will be amended to reflect that information regarding the prisoners health has been sought, and a decision taken on whether risk assessments need to be reviewed in line with the advice issued in April 2008 by Security Group.'

Compassionate Release

73. The compassionate release process is available nationally. It has a specific criterion which indicates that, for the application to be successful, ill/dying prisoners should have a life expectancy of three months or less. Written confirmation of this is required to support applications submitted and the process can, in some cases, take a long while to complete. The Head of Healthcare acted quickly to obtain written confirmation of the man's prognosis on 16 April. This was provided by the hospital and submitted on 17 April, together with the necessary application. The decision on the man was taken and communicated relatively quickly, within four days of being received. However, this was the day after the man's death.

Conclusion

74. The man began his sentence in May 2007. Until early 2008, when his symptoms first appeared, he was considered to be a fit man. The clinical review has concluded that he was appropriately assessed and quickly referred to secondary care. There are, however, some concerns around his end of life care. The review has also drawn attention to some deficiencies in record keeping, but these are not considered to have adversely impacted on his medical condition.

75. The issue of wider significance concerns the use of restraints. I am not sure it was reasonable that the man was subject to restraints for as long as he was.

Family's response to the draft report

76. After the draft report was issued, the investigator spoke with the man's daughter. The man's ex-wife explained that she had been happy with the content of the report, but felt there were a number of issues she would like to be mentioned that my investigator had not been aware of during the investigation.

77. She said that when the man was in the hospital the prison had informed hospital staff that her father was a sex offender. The man's former wife felt that this information was unnecessary and that it led to both her father and the family being treated differently by medical staff. The investigator has been unable to substantiate this issue, so my comments on this aspect are somewhat hypothetical. Although I am unable to comment on the way in which this information might have affected the attitude of the medical staff towards the man and his family, I do agree that the manner in which it was provided appears to have been inappropriate in this case. The man was indeed serving a sentence for an offence that would require him to register as a sex offender on his release from custody. However, if it is the case that the prison provided this information, they should have been more explicit the level of risk which the man posed. The man's offence did not indicate that he was an immediate risk to women, but it seems that the information provided did not properly explain this and therefore may have led to inaccurate assumptions about him.

78. The man's daughter had initially been very concerned by the use of restraints on her father when he entered hospital and was pleased when the decision was finally made to remove them. However, she said that both she and her mother had found the continued presence of prison staff in the room during visits failed to show the level of decency that she expected. Being able to spend time with her father before he died was important to her and I feel that it would have been decent for staff to allow the family time alone to say goodbye. The man was in a side room with only one entrance, therefore it would not have been difficult for arrangements to be made for the staff present to be positioned outside the room. I also feel that this would have been less traumatic for those staff present at the time of the man's death.

79. As previously mentioned in the report, an application for compassionate release was made for the man. Regrettably, a decision authorising his release was made the day after he died. The man's daughter told my investigator that she felt that the application process could have been started much sooner and that would have allowed her father the opportunity to be released from custody. However, my investigator explained that the process requires clinicians to provide certain information that is, at times, difficult for prisons to obtain until the prisoner's condition has deteriorated significantly. As a result, this all too often leads to prisoners dying before the decision on their release is communicated to the prison. The man's daughter was keen for this problem to be highlighted in the report.

RECOMMENDATIONS

1. The Head of Healthcare should consider updating the training on reception interview skills to assist staff with ascertaining crucial previous medical history and observing the patient.

2. The Head of Healthcare should consider the relevance and importance of obtaining previous clinical records for prisoners, particularly when a life sentence is given.

3. The Head of Healthcare should ensure that the Protocol for Receiving New and Returning Prisoners into HMP Gloucester is updated to instruct staff of the correct place to record additional information.

4. The Head of Healthcare should consider updating training and guidance for all healthcare staff in relation to record keeping. In particular, they should be reminded of their obligations to comply with the guidelines regarding record keeping set out in the relevant Nursing and Midwifery Council Guidelines.

5. The Head of Healthcare should look into improving transfer information in relation to clinical issues.

6. Care of prisoners at the end of life should be included as part of the local PCT GSF development work.

7. A protocol should be agreed with local palliative care specialists in relation to triggers for referral and accessing specialist advice and support, to include liaison with friends and relatives and communication with other parties/agencies within and outside the prison.

8. The Head of Healthcare should instruct staff to make every effort to avoid cancelling important investigations, particularly those related to urgent medical care. Consideration should also be given to making alternative escort arrangements in exceptional circumstances.

9. The Governor should ensure that the local security procedures relating to escorts and bedwatches are updated to reflect the revised national guidance issued in February 2008 relating to seriously ill or dying prisoners.