Investigation into the circumstances surrounding the death of a man in May 2010 whilst in the custody of HMP Shrewsbury

Report by the Prisons and Probation Ombudsman for England and Wales

April 2011

The man was 53 years old when he died in a nursing home in Shrewsbury in May 2010. He had been diagnosed with cancer a few weeks earlier. The Coroner recorded the cause of death as carcinomatosis (meaning that the cancer had spread widely throughout his body).

The man previously complained of some pain at HMP Hewell between December 2009 and February 2010. He underwent tests which gave no indication of what might be wrong. Within a week or two of his arrival at HMP Shrewsbury at the start of March 2010, healthcare staff ordered more tests because he was not looking at all well and was complaining of severe pain. He died less than three months later. When the cancer was diagnosed, it had already spread to his bones and his prognosis was very poor. He accepted that he did not have long to live and his treatment in his last few weeks focussed on pain relief to ease his discomfort.

The man is survived by a number of family members. I would like to take this opportunity to express my sincere condolences to them for their loss.

The investigation was completed by my colleague. He visited both Shrewsbury and Hewell, speaking to both discipline and healthcare staff. One of my Family Liaison Officers contacted the family to tell them about the investigation. She continued to liaise with the family after the draft report was published.

A clinical review of the treatment which the man received in prison was undertaken by a panel led by a clinical reviewer appointed by the local Primary Care Trust (PCT). The panel judged that the care he received in custody was comparable to that he would have been offered in the community. I am grateful to the panel for their assistance.

I would like to express my thanks to the Governor and the staff and prisoners at Shrewsbury for their full cooperation whilst the investigation was completed.

The investigation has found that the man was offered a good level of care at Shrewsbury. Staff made considerable efforts to speed his diagnosis and to look after him as his health rapidly deteriorated. The joint efforts of the prison staff and the hospital meant that he was able to end his life in the more comfortable and humane surroundings of a nursing home. Consideration was given to releasing him on compassionate grounds, but events unfolded very rapidly and I support the Governor's view that he benefited from the presence of a prison officer as a bedwatch escort. I make one recommendation and endorse four others made by the clinical review panel.

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

Jane Webb
Prisons and Probation Ombudsman **April 2011**

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SUMMARY

The man arrived at HMP Hewell from court on 4 December 2009. He said that he had recently had pneumonia but did not report any potentially life threatening physical health problems such as cancer. During his first month in Hewell, he was given several warnings for attempting to conceal rather than swallow his medication in order to repay a drugs debt that he owed to another prisoner.

Over the new year, the man reported pain in his kidneys and back on several occasions. A urine test and x-ray gave no indication as to the cause of the pain. He spoke to a doctor about his discomfort in mid-February. The doctor prescribed pain relief. Whilst at Hewell, his mental health was regularly assessed because he had previously experienced drug induced psychosis.

On 1 March, the man transferred to HMP Shrewsbury. He did not report any chronic health problems during his initial health screen. However, over the next few days, he began reporting pains in his hip and staff initially gave him paracetamol. Once again, a community psychiatric nurse regularly reviewed his mental health. On 11 March, a nurse referred him to the doctor for his hip pain and because he looked frail. He had suddenly lost a lot of weight and the doctor ordered tests. Staff noticed that he had visibly aged since his arrival at Shrewsbury.

Over the next few weeks, the man underwent a number of tests at hospital. Staff at the prison tried to hurry along the tests because they were concerned about him. He was admitted to the hospital between 27 and 28 March when his health declined, and again between 8 and 13 April. He discharged himself from the hospital on 13 April against medical advice. When he returned to the prison, staff drew up a care plan because he could no longer look after himself independently.

A couple of days later, the man made a written complaint to the Governor about the pain relief he was receiving. Staff responded and he does not seem to have expressed any further dissatisfaction with his treatment during the weeks that followed. Healthcare staff arranged for him to be taken to hospital on 17 April, after he became more unwell. He underwent further tests and was diagnosed with an aggressive form of cancer which had spread to his bones.

The man was too unwell to return to Shrewsbury, which has no inpatient facilities. Staff tried to locate a bed in a prison with better healthcare facilities, but none was available. He was told by the hospital consultant that his prognosis was very poor and that he would only live for another few weeks. Hospital staff found him a place in a nursing home and he moved there on 10 May after receiving radiotherapy treatment to try to slow the progress of the cancer.

From the time the man received his diagnosis, he was not handcuffed to his escorting officers. From 14 May, only one officer was required to stay with him at the nursing home. Although his release on compassionate grounds was considered, and assessments were completed, events unfolded quickly and he seemed to benefit from the company and assistance that an officer provided. He died in the nursing home.

THE INVESTIGATION PROCESS

1. The investigator was formally notified of the man's death on 28 May 2010. Notices were subsequently issued to both staff and prisoners at HMP Shrewsbury, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.

2. The investigator liaised with the Deputy Governor at Shrewsbury throughout the investigation. He visited Shrewsbury on 7 June and was provided with all the documents relating to the man's time in custody. Whilst there, he spoke to several staff about his care.

3. The investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation. HM Coroner will be provided with a copy of the report of the Ombudsman's investigation.

4. The investigator also contacted the local PCT and asked that a review be carried out with regard to the clinical treatment which the man received at Hewell and Shrewsbury. The purpose of the review is to establish whether the care that he was offered in prison was comparable with that he would have received in the community. A panel completed the review. The clinical reviewer and the investigator visited Hewell to interview two members of the healthcare staff on 7 July.

5. One of my Family Liaison Officers contacted the man's brother to discuss the investigation and to find out if the family had any concerns about the treatment he received. His brother did not have any specific concerns he wished the investigator to address. He spoke very positively about the compassionate way that prison escort staff had treated his brother at the nursing home. However, he said that he had yet to receive his brother's property from Shrewsbury. The investigator contacted the liaison officer who agreed to send his belongings to his brother immediately.

6. After the draft report was published, the man's siblings contacted the Family Liaison Officer to ask for a meeting with her and the investigator to give their feedback. The meeting took place on 14 January 2011. I have added a section to the final report to reflect the family's opinions, beginning on page 31.

HMP SHREWSBURY

7. Whereas Shrewsbury used to accept prisoners on remand from the nearby courts, recently this function was largely reallocated to HMP Dovegate. The prison will now receive mostly longer term sentenced prisoners. Shrewsbury accommodates a maximum population of 340 men.

Healthcare

8. The healthcare department at Shrewsbury does not have any inpatient facilities. There is 24 hour nursing cover. Throughout the night a nurse and a healthcare assistant remain on duty. Doctors' surgeries are held every afternoon from Monday to Saturday. Until the man fell ill, the prison had not previously had to address the issue of palliative care (when a patient will not get better and the priority is to make him as comfortable as possible as his health declines). The healthcare staff are presently drawing up a palliative care policy and examining the needs of older prisoners in general. This has become a salient issue since the prison changed functions and the average age of prisoners consequently increased.

Her Majesty's Inspectorate of Prisons

9. HM Chief Inspector of Prisons completed an inspection of Shrewsbury in June 2006. She found that Shrewsbury was a 'reasonably safe and relaxed' prison, in spite of its ageing infrastructure and continued overcrowding. However, she noted that the opportunities available to prisoners to keep themselves constructively occupied were 'severely restricted'. Some cells were unfit for purpose. Despite the limited resources available, she wrote that the healthcare department provided 'a good service'.

10. HM Chief Inspector of Prisons completed a short, unannounced follow-up inspection in February 2010. She described Shrewsbury as a 'singularly poor choice' for a training prison but noted that the provision of healthcare was 'much improved'.

Independent Monitoring Board

11. The most recent annual report published by the Independent Monitoring Board (IMB) at Shrewsbury covers the year from May 2008 to April 2009. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB noted 'severe staff shortages' in the healthcare department and called for closer cooperation between the prison and the local Primary Care Trust in order to explore staff retention.

Previous deaths at Shrewsbury

12. The Ombudsman assumed responsibility for investigating deaths in custody in 2004. Since that time, I have investigated nine previous deaths of which eight

were self inflicted and one was the result of natural causes. There are no significant similarities between the circumstances of the man's death and those of the other prisoners.

Performance

13. The most recent prison quarterly ratings published by the Ministry of Justice show that Shrewsbury scored 3 overall, indicating a good performance. The prison achieved the same score in the previous quarter. The minimum score is 1 (serious concerns) and the maximum is 4 (exceptional performance). The rating takes into account 34 different aspects of the way the prison is currently operating.

KEY FINDINGS

14. Having received a prison sentence of three and a half years for domestic burglary, the man arrived at HMP Hewell on 4 December 2009 from Crown Court. He had been discharged from prison nine weeks earlier and did not have a permanent address.

15. Upon arrival, the man underwent a routine initial health screening. Although he had a long history of drug and alcohol misuse, he said that he had not taken drugs for two years. He was not therefore referred to a substance misuse worker. Nurse A wrote that he looked physically well. The nurse recorded that he had been hospitalised with pneumonia five weeks earlier but did not have any concerns about his physical health.

16. The man was prescribed an inhaler for his asthma, medication for his epilepsy and anti psychotic medication for mental health problems. He had been admitted on several occasions to psychiatric care over the years as a result of drug induced psychoses. He had displayed symptoms of schizophrenia in the past and told the nurse that he had gone to an appointment with his psychiatrist in the community three weeks before.

17. During the assessment, the nurse did not think the man seemed depressed or showed any signs of serious mental illness or psychosis. He presented as stable and good humoured. Nonetheless, he referred him to the In-Reach team (who treat prisoners with severe mental health problems). He reported that he had been under the care of another In-Reach Team until his recent release from custody.

18. The man was located in a single cell because he said that he found it difficult to share with others. Staff completed a Cell Sharing Risk Assessment, (CSRA) and assessed him as presenting a low risk to other prisoners. He completed an application for vulnerable prisoner status (otherwise known in prison as asking for 'rule 45'). It is not clear from the paperwork why he made this request.

19. Prison Doctor A assessed the man the following day, 5 December. He was allowed to keep his anti psychotic medication and inhalers 'in possession' instead of the nurses giving it to him at set intervals. The doctor thought that he looked well but noted a history of chronic obstructive lung disease. Nurse A completed a full secondary assessment of his health the same day.

20. On 8 December, the man was classified as a category C prisoner. (Category A and B prisoners are considered to represent a higher risk if they escape, whilst category D prisoners are trusted to live in open conditions.)

21. The man was assessed by Community Psychiatric Nurse (CPN) A on 11 December. (She had previously met him when he was held at Hewell in the summer.) She went to speak to him in his cell and found no signs of significant mental health problems. However, the assessment was cut short

because he said that he was experiencing pains around his kidneys in the lower back area.

22. Prison Doctor B assessed the man the same day. He said that, when he urinated, he passed blood and experienced a burning sensation. The doctor sent a urine sample to be tested and ordered x-rays to find out more about the pain in his kidneys. He thought he might be suffering from kidney stones. The doctor prescribed cephalexin (a treatment for urinary tract infections) and diclofenac (an anti-inflammatory drug).

23. Prison Doctor A reviewed the results of the urine test on 13 December and advised that no further action be taken because the results were normal.

24. On 15 December, the man's in possession medication for his urinary infection was removed after he tried to 'palm' it (meaning that he would pretend to swallow it, but actually conceal it in order to sell it on to other prisoners). He was told to collect his medication from the hatch instead. He was cautioned under the Incentives and Earned Privileges (IEP) Scheme. (The IEP scheme is intended to encourage and reward good behaviour. Additional entitlements can be gained in return for good behaviour. However, those entitlements can be lost if the prisoner's behaviour deteriorates. Prisoners can be placed on either a basic, standard or enhanced regime.)

25. The next day, 16 December, the man was supposed to attend hospital for an x-ray, but no staff were available to escort him and so he could not go. On 18 December, he went to another appointment with the CPN. Again, she had no significant concerns about his mental health. His state of mind seemed to be much improved in comparison to previous periods in custody. He said that his mood had improved because his kidney pain had decreased.

26. The man's rescheduled x-ray appointment took place on 23 December. The CPN assessed him again on 24 December. She noted a family history of mental health problems and alcohol misuse. She recorded that he had become institutionalised after numerous custodial sentences and that he coped well in prison. He told her that he had used 'every drug in the world' at various times in his life.

27. On 28 December, the man was placed on report for again trying to 'palm' his medication. On 29 December, he was given another warning under the IEP Scheme for the same reason.

28. A Security Information Report (SIR) dated 5 January 2010 stated:

> 'He has asked staff to keep his canteen back on Friday 08.01.10 as he has to pay back his drug debt. Apparently his canteen sheet was taken off him and someone else filled it out and handed it in.'

29. Staff thought that the man might be assaulted by a fellow prisoner if he did not pay back his drug debt. Illegally obtained subutex (a heroin substitute) seems

to have been circulating amongst several prisoners on the wing, prompting him to palm his medication.

30. The man was due to go to an appointment with the CPN on 5 January, but she was unavailable and the assessment did not take place. Prison Doctor B reviewed his x-ray on 7 January and recorded that no kidney stones were apparent.

31. On 8 January, the man (and some other prisoners) told staff that they were being bullied for their medication by another man. The following day, he was asked to confirm in writing that he felt safe associating with the other prisoners on the wing. He did not attend a scheduled mental health assessment on 13 January.

32. During an assessment on 15 January, the man asked the CPN if he could talk to a psychiatrist. He wanted to request stronger mental health medication because he did not feel that his current prescription was having the intended effect. He mentioned that he had used alcohol and cannabis whilst in custody over the Christmas period. She thought his mood was bright and that he presented as 'mentally stable', but booked an appointment with the doctor for 25 January (although the appointment eventually took place on 4 February).

33. On 18 January, the man was given another warning under the IEP scheme for failing to attend work. On 28 January, he was given a further warning for the same reason and moved from the standard to the basic regime (meaning that he lost some privileges). Towards the end of January, he was repeatedly prescribed doses of paracetamol.

34. At the start of February, the man complained to staff again of pain in his kidneys and blood in his urine. He provided a urine sample, which staff concluded looked normal. On 3 February, he met the CPN and said that the pain in his kidneys was affecting his mood and ability to sleep. He also told her that he had recently refused to go to work (and consequently been placed on report) because of the pain he was experiencing.

35. The next day, 4 February, the man was assessed by a psychiatrist. The psychiatrist noted that he had complained of ongoing kidney pain for the past seven weeks and that it became worse when he urinated. He wrote that his urine sample was normal and that the recent x-ray showed 'no abnormalities detected'. He said that the pain was stopping him sleeping. He asked for pain relief and was given paracetamol over the next few days. The psychiatrist referred him to the general practitioner.

36. The man was assessed by Prison Doctor C on 12 February. He asked for pain killers for the 'crippling' pain in his back. The doctor wrote that he claimed to have passed blood in his urine and was 'drug seeking'. He prescribed naproxen (a non steroidal anti-inflammatory drug used to reduce pain).

37. On 13 February, the man received a further IEP warning for having a television (something not permitted under the basic regime).

38. The CPN assessed the man again on 16 February. He said that he was still experiencing some pain despite his new medication. He showed no sign of mental health problems. Nurse B assessed him on 19 February. He complained of tightness in his chest. He had not been using his inhalers and said that they had run out. The nurse provided him with new inhalers.

39. The man went to healthcare staff as an emergency on 25 February and asked Nurse C for two paracetamol tablets. She issued them as a one-off immediate prescription.

40. On 1 March 2010, the man was assessed by healthcare staff as 'fit to transfer' before moving to HMP Shrewsbury. The move was not unusual, as he was a long term sentenced prisoner. Hewell functions predominantly as a local prison accepting men on remand from nearby courts and needs to progress sentenced prisoners to other nearby prisons. Shrewsbury has recently changed its function and now accepts mostly sentenced prisoners.

41. During the man's initial health screening in the reception area, he told Nurse D that he had epilepsy, short term memory loss (the result of a head injury 25 years previously) and asthma (for which he was given an inhaler). He again reported mental health problems related to his long standing drug misuse and was referred to the In-Reach Team.

42. Staff completed a CSRA and decided that the man presented a low risk to other prisoners. He was assessed by Prison Doctor D and his prescriptions were continued. There does not seem to have been any discussion of the pain he had been reporting recently at Hewell, although the details were contained in the clinical record that arrived with him.

43. The man underwent a second health screening on 3 March. He confirmed that he had suffered from fits since having a brain haemorrhage in 1985. His fitting was the only issue identified under the section of the form marked 'Chronic health concerns'. Officer A interviewed him the same day. He was placed on the standard regime under the IEP scheme.

44. Because staff thought the man looked frail, he was located in a cell near the wing office. He was given paracetamol for hip pain on 5, 7, 8 and 9 March.

45. On 10 March, the man was assessed by CPN B from the In-Reach team). They discussed his history of drug induced psychosis, something he told her no longer affected him. During the interview, he was 'bright, chatty and cooperative'. He told her that his mood was only affected by the pain in his hip. She referred him to a psychiatrist to review his medication. She also drew up a care plan for his mental health treatment with his help.

46. The next day (11 March), the man was assessed by Nurse D and they discussed the severe pain in his right hip which he had been experiencing for

the previous two weeks. The nurse noted that he looked frail and pale and that there was no relevant history in his clinical record. She referred him to Prison Doctor D. Later that day, he told the doctor that he had lost weight (half a stone in the space of a week). The doctor noted that he was anaemic, prescribed co-codamol (a painkiller) and ordered full blood tests and a chest x-ray.

47. Shortly before 6.00am on 13 March, the night officer on the wing found the man and another prisoner smoking cannabis. No disciplinary action was taken. On 15 March, he was escorted to hospital for x-rays. The results were expected within seven to ten days.

48. Prison Doctor E looked at the results of the first blood test on 17 March and ordered an immediate follow-up blood test because the results were concerning and inconclusive.

49. A second, urgent blood sample was taken on 18 March and sent to the hospital by taxi for testing. The doctor compared the man's appearance with his photograph taken at reception on 1 March and wrote that 'he appears to have aged 30 years in 17 days'. He observed that he could still walk, could talk coherently and looked 'pale but not ghastly'. He noted that his main complaint was the pain in his hip and prescribed tramadol (a pain killer). The doctor wrote:

> '…I think he's got a chronic process gradually deteriorating, rather than anything acute…'

50. The results of the second blood test were telephoned through from the hospital on the same day. The doctor noted that the results were still 'awry'. Healthcare staff called the hospital on behalf of the doctor to obtain the man's x-rays but were told that they were not yet ready. The doctor thought he had an 'acute [chest infection] on [top of] chronic [ill health]'. His asthma and blood pressure were checked by a nurse.

51. The same day, the man attended a smoking cessation clinic. He was given advice on how to stop smoking and provided with nicotine patches. CPN B also assessed him again on 18 March and did not identify any mental health problems.

52. On 24 March, the man received further advice about stopping smoking. On the same day, Prison Doctor E wrote that the blood tests taken on 18 March gave further cause for concern. (The hospital had not yet returned the results of the chest and hip x-rays taken on 15 March.)

53. A nurse assessed the man on 25 March. She noted his ongoing hip pain and wrote that his pain relief (tramadol) was not helping sufficiently. More blood tests were carried out on 26 March. On the same day, he underwent a 'Health and Social Care Assessment for Prisoners Aged 50 and Over'. It was noted that he had a cyst behind his left ear that had been getting bigger over

the previous six months. His breathlessness and hip pain were also recorded, as was his weight loss of half a stone in the previous three months.

54. Following an assessment on Saturday 27 March, another nurse became concerned and consulted a doctor on duty at a nearby prison, HMYOI Stoke Heath by telephone for further advice about the man's symptoms. The doctor thought that he should be admitted to hospital the same day.

55. The man was taken to hospital where he stayed overnight, returning the following day, 28 March. It was thought that he had had an internal bleed and he was given a blood transfusion, although this was not completed because his temperature rose during the procedure. The consultant surgeon decided that his ill health required further investigation.

56. On 29 March, the man went to the hospital again to undergo a scheduled endoscopy and colonoscopy (a procedure which allows a doctor to look at the inside of a patient's digestive system using a tiny camera that is fed through on the end of a tube). However, the hospital had no record of the appointment and he was brought back to the prison without the procedure taking place. A member of healthcare staff contacted the ward where he had just been staying. The ward staff agreed to speak to their colleagues about the delayed procedure. The same day, Nurse E noted that his temperature was raised and gave him a paracetamol to lower it.

57. The next day, 30 March, Nurse D called the hospital to check if a new appointment had been arranged for the man's endoscopy. She was told that the new referral from the ward had not yet reached the relevant department but would do so later that day. His temperature remained raised and Prison Doctor E continued to prescribe paracetamol to keep it down.

58. On 31 March, the man went back to the smoking cessation clinic. The same day, he complained to a senior member of healthcare staff that he felt 'lousy'. He was checked by Prison Doctor E.

59. The next day, 1 April, the senior member of healthcare confirmed with hospital staff that the man's endoscopy and colonoscopy had been rescheduled for 16 April. She also telephoned the hospital laboratory, who advised her that tests to rule out tuberculosis could take up to ten weeks.

60. A nurse was asked to assess the man in his cell on 2 April. He was feeling faint, looked very pale and his hands were shaking. During the next few days, he continued to smoke, but told staff that he felt a little better.

61. On 6 April, the man went to a psychiatric assessment with a consultant psychiatrist. She had organised the assessment because she thought that his medication for his mental health problems (the result of his long term drug misuse) needed to be reviewed. He was being prescribed risperidone and chlorpromazine (both antipsychotic drugs). He said that he was not experiencing psychotic symptoms and she ended his risperidone prescription,

instead prescribing mirtazapine for depression. He said that he was having trouble sleeping due to the pain in his hip.

62. A nurse went to assess the man in his cell on 7 April after officers on the wing expressed concern about him. He had not eaten for a couple of days and felt shaky and lethargic. His temperature was fluctuating. The same day, Prison Doctor E enquired with the hospital whether his colonoscopy could be scheduled any earlier in order to hurry a diagnosis along.

63. A nurse reviewed the man in his cell early on 8 April. He was no longer shaking but complained of the pain in his hip. A short while later, the nurse was called back to the cell to find him lying on the floor. He had been unable to reach the toilet and felt so weak that he lay down and could not get back up. He was awake and uninjured. However, the nurse noted that he was very frail and his health was deteriorating. Staff helped him back to his bed and the nurse gave him paracetamol to lower his temperature. The nurse noted that his colonoscopy had not been brought forward, despite Prison Doctor E's request. He returned to check on him a little later on.

64. Another nurse assessed the man shortly afterwards. She noted that his condition had deteriorated within 24 hours. He had stopped eating solid food and looked frail. She referred him to Prison Doctor E because she thought he should be taken to hospital. The doctor agreed and he was admitted to the hospital's accident and emergency department at 10.30am.

65. The man stayed in hospital between 8 and 13 April because he was too unwell to return to the prison. On 9 April, the senior member of healthcare and Prison Doctor D advised discipline and healthcare colleagues that he should not return to the prison until his condition had stabilised. On the same day, he underwent an endoscopy. His stomach, windpipe and small intestine were checked but no serious concerns were identified. He received blood transfusions but his temperature remained raised.

66. On 13 April, the man discharged himself from hospital against medical advice and returned to the prison. He wanted to attend any tests and appointments as an outpatient. Although hospital staff told him that his decision might delay his treatment, he insisted. His discharge summary detailed the medication he needed to take. He could no longer walk any significant distance without collapsing.

67. Healthcare staff drew up a care plan on 13 April. It was agreed that staff would help the man to maintain his personal hygiene (because he was unable to do this independently) and ensure that he took all of his prescribed medication. Staff also arranged to give him a sedative to help him sleep at night (if the doctor thought this appropriate) and administer pain relief when needed because of the trouble his hip was giving him. A nursing assessment noted that he had been reporting constant kidney and back pain.

68. The man's temperature and other clinical observations were checked each day. The Clinical Nurse Manager assessed him in his cell on the morning of

15 April. His right leg and hip caused him constant pain and he could only eat tiny amounts of food because otherwise he tended to be sick. His discomfort was getting worse and he asked for increased pain relief. A CPN checked him the same day and noted how much his health had deteriorated and mobility reduced in recent weeks. He said that he was depressed because he was in constant pain.

69. On 15 April, the man made a formal complaint to the Governor. He wrote:

> 'Sir, I am in chronic pain in right hip and I am now suffering in chronic pain and not getting any pain relief from medical staff. As you know discrimination of a disabled person is unlawful and this prison is clearly discriminating against me as a very very ill prisoner. I wish you to know I have asked solicitor to have a public enquiry in the event of my death in custody. I wish to be moved into a prison with medical help.
>
> 'I want to go into a prison who can control my chronic pain, as med care is not helping me or I know you will have a death on your hands very soon. I have asked the Ombudsman to also investigate the treatment I am receiving here.'
>
> (The Prisons and Probation Ombudsman investigates complaints from prisoners but did not receive a complaint from him. He did complain to the Parliamentary and Health Service Ombudsman (PHSO) in April. However, the PHSO have been unable to disclose to my investigator either the details of the complaint or the outcome.)

70. The next day (16 April), the man was escorted to hospital for a colonoscopy. At 7.00pm that day, a Healthcare Assistant checked him in his cell. He had not eaten or drunk much at all and was sweating a great deal.

71. On the afternoon of 17 April, a nurse consulted Prison Doctor F. They were very concerned about the man and arranged for him to be taken to the hospital at 4.30pm. However, at 6.15pm he was still waiting in an ambulance outside the hospital as no bed was available. He was admitted later in the evening and was made comfortable.

72. Following a risk assessment, the man was initially handcuffed at all times to one of the two escorting officers using an escort chain. (An escort chain consists of a length of chain with handcuffs at both ends. It allows a prison officer to remain a few feet from the prisoner and permits hospital staff to take care of the patient without the officer getting in the way.)

73. A senior member of healthcare visited the man in hospital at 2.00pm on 19 April. He had received a diagnosis of secondary cancer in his bones. (There was concern that his bones were so fragile as a result of his condition that he could easily fracture them.) The primary source of the cancer was unknown. He was located on the oncology ward, told his diagnosis and given adequate pain relief.

74. A further risk assessment on 19 April approved the removal of restraints because the man's condition had deteriorated. He was no longer handcuffed to an officer and would not be again before he died. The two escorting officers remained with him for the time being.

75. The senior member of healthcare discussed possible treatment options with the ward staff. She explained to them that the prison healthcare team did not have the facilities and resources to care for the man in Shrewsbury. They discussed the possibility of release on licence (if a prisoner is terminally ill then they may be released from custody for compassionate reasons), but concluded that this might not be an appropriate option because he had no permanent address when he arrived in prison. They agreed that it was not yet appropriate to move him to a hospice, which only happens at the end of the patient's life.

76. The man's condition was reviewed by a consultant during ward rounds on 20 April. The consultant noted that he had been in pain for six weeks and that the primary cause of the cancer in his bones had not yet been determined, in spite of an endoscopy, a bone scan and x rays. The consultant noted that his chest, pelvis and abdomen would need to be examined to discover where the cancer had begun. The escorting officers told him that his daughter had been trying to get in touch with him.

77. The Head of Reducing Reoffending responded to the man's complaint on 20 April. She wrote:

> 'He was interviewed by a governor whilst at the hospital doing management checks. He stated that … he did not have an issue with the PCT but he had with the doctor which he is taking further outside of this complaints procedure.
>
> 'Healthcare staff locally were advised of the situation. His condition is serious but not yet fully diagnosed.'

78. The next day, the senior member of healthcare also responded to the man's complaint. She wrote:

> 'Thank you for bringing this to my attention. I am sorry to hear that you are still in pain, but you have been receiving strong pain relief (ie. tramadol) since 29.3.10.
>
> 'You have been seen by the doctor and the nursing staff on a regular basis, have had extensive investigations and have been admitted to the hospital on several occasions.
>
> 'In future please inform your landing staff of any concerns and a member of the healthcare staff will come and see you.
>
> 'Please also contact me again if you have further problems. This complaint was not received by healthcare until 21.4.10.'

79. Scans of the man's abdomen did not reveal the primary cause of his cancer. He underwent a colonoscopy on the morning of 21 April. Whilst his colon was not affected (the bowel was 'normal'), the test revealed a mass on his right side 'going into his spine' and a biopsy was scheduled. It was noted that his cancer had spread to the bones in his arm and leg. The primary source of the cancer was still not determined. The same day, the senior member of healthcare tried to establish whether he had any accommodation to which he could be released.

80. The next day, the senior member of healthcare confirmed with the man's most recent probation officer that he had been homeless when he arrived in prison. She recorded that the likelihood of him being offered any other accommodation (where he might be released on licence) was now 'unrealistic', given his history of offences of theft and his fragile condition.

81. The man underwent a biopsy (the removal of cells for further examination) of the lesion on his right hip on 23 April. By the following day, he could no longer walk and was confined to a wheelchair. He asked the escorting officers to contact his brother on his behalf.

82. On 26 April, hospital staff confirmed to the senior member of healthcare that the man would not be able to cope if he was released to a private address and they agreed that he would need to be admitted to either a nursing home, a hospice or a prison with proper inpatient facilities. His morphine dosage was increased. Staff again telephoned his brother on his behalf on the evening of 27 April. (He had also been in touch with his brother personally.)

83. The day afterwards, the senior member of healthcare was advised by the hospital staff that the man could expect to live for about another four weeks. He was told by the consultant that afternoon (28 April) that the cancer was 'extensive and difficult to treat'. His pain relief was increased.

84. The need to find a suitable facility to which the man could be discharged was pressing. The senior member of healthcare spoke to staff at HMP Dovegate, HMP Norwich, HMP Birmingham and Hewell, all providing inpatient healthcare, but none had an available bed. She discussed the situation with Deputy Governor, who suggested that he might be released on temporary licence once he became bed-bound.

85. The next day, 29 April, the senior member of healthcare was told by hospital staff that a bed had been found for the man at a nursing home. The manager of the home agreed to accept him on the condition that the escorting officers did not wear a prison uniform. She also indicated that she would continue to accommodate him if he was released on compassionate grounds (and was therefore no longer escorted by prison staff), providing that he did not present a risk to others. The senior member of healthcare noted in the clinical record that his pain was being controlled and he was able to walk slowly using a Zimmer frame.

86. The same day, the man was assessed by an oncologist. The oncologist wrote that the cancer which had spread through his bones had probably begun in his lungs. He was located in a side room at the hospital with two escorting officers. The oncologist told him that his condition was treatable but not curable because the cancer had spread. He understood that his prognosis was not good and agreed to accept radiotherapy. (The oncologist considered that he was too poorly to undergo chemotherapy.) He was told not to try to walk but instead to use his wheelchair. Staff telephoned his brother again that evening to update him.

87. Also on 29 April, a seconded probation officer in Shrewsbury completed part of a report about the man's possible early release on compassionate grounds. She assessed that there was a high likelihood of him committing further offences of theft and noted that he did not have any family or friends who would be willing to look after him.

88. She wrote that the man had a history of misusing substances and then reoffending very soon after release. He was registered as a prolific offender and had previously breached licence conditions. She commented that he had become institutionalised and usually returned to prison very rapidly after release into the community. She expressed concern that he would not attend his hospital appointments if he was released and no longer had prison officers to escort him. She noted that release to a hostel would be 'wholly unsuitable'.

89. The senior member of healthcare visited the man at the hospital the following day, 30 April. She was told that he would undergo radiotherapy and then be discharged to the nursing home within seven to ten days. She spoke with him about his diagnosis and he expressed his pleasure that his brother would be visiting him. He was supposed to undergo an MRI scan (which provides an internal image of a patient's body) the same day, but this could not happen because he had a piece of metal in his head from a previous operation. He was told that he had developed a fracture in his arm because the cancer had weakened the bone so much. Hospital and prison staff had to take great care when moving him.

90. On the same day, at the request of the governor, Prison Doctor D completed a 'Compassionate medical condition report' to assess the man's application for early release on compassionate grounds. He wrote on the form that he had terminal lung cancer which had spread to his bones. He noted that his prognosis was 'extremely poor' and that he had less than four weeks to live. The doctor strongly recommended early release on compassionate grounds.

91. At the start of May, the security department decided that the man would be allowed as much tobacco as he needed because he was dying and it gave him some pleasure and relief. The escorting officers were asked to escort him from his bed to a designated outside smoking area when he wanted to smoke. He could no longer either get out of bed or use his wheelchair because of the fragile state of his bones and his swollen feet.

92. On 2 May, the man spoke to his brother on the telephone. He started his course of radiotherapy two days later on 4 May. His bones were so fragile that he broke his arm again whilst turning over in bed and it was put in a plaster cast.

93. The man refused radiotherapy on 7 and 8 May. A nurse rang the hospital on 8 May on behalf of the healthcare department (after the escorting officers expressed concern) but was told that he was currently consenting to treatment. His relatives visited him on 8 May.

94. On 10 May, the man again declined his radiotherapy session and expressed his wish to simply move to the nursing home. He transferred to the nursing home the same day and attended further radiotherapy sessions as an outpatient at the hospital on 11, 12 and 13 May. Healthcare staff provided him with nicotine patches because the nursing home would not allow smoking inside the building. However, escorting officers would still take him to smoke in the garden.

95. A member of staff at the nursing home telephoned Prison Doctor D on 11 May to suggest that the man be registered as a patient at a nearby doctor's surgery. Healthcare staff faxed a copy of his clinical record through to the new surgery. The prison doctor spoke to a doctor at the surgery to provide a handover about his condition.

96. The man was given a palliative care Macmillan nurse whom the senior member of healthcare spoke to on 12 May. Two days later, on 14 May, the senior member of healthcare visited him in the nursing home. She noted that he was comfortable and well looked after. He acknowledged that he was dying and asked for the Anglican chaplain to visit him. Following a visit by the duty governor and a further risk assessment the same day, only one officer was required to escort him in the nursing home from the evening of 14 May onwards.

97. The man's sister visited him on 15 May, and he went to an appointment at the hospital shortly afterwards to have his plaster cast changed. The senior member of healthcare visited him on 17 May. He had very little mobility and used a Zimmer frame to move to the bathroom with a member of staff present in case he got into any difficulties. His pain relief medication was increased. The next day, he returned to the hospital to have his plaster cast changed again because the wound underneath the cast was weeping.

98. On 20 May, the man's offender supervisor wrote a report concerning his possible early release. He referred to his numerous previous convictions for domestic burglaries and the fact that he had previously stolen from relatives. Previous risk assessments also recorded that he enjoyed the 'buzz' associated with stealing and was unlikely to stop. The officer supervisor expressed reservations about him being left on his own in the nursing home without an escorting officer because of the likelihood of further offending. The same day, he went back to hospital to have his plaster cast checked.

99. The next day (21 May), the oncologist at the hospital wrote to the healthcare team to tell them that the man had completed his course of radiotherapy. On the same day, healthcare staff renewed their efforts to find an inpatient bed for him in another prison. The clinical nurse manager and a governor visited him the same day. The governor visited again on 24 May and organised for him to be given more tobacco.

100. The man spoke to one of his brothers on the telephone on the evening of 26 May. Just after midnight, a doctor came to check him and increased his pain medication. The clinical nurse manager and the prison chaplain both visited him in the nursing home on 27 May. She noted that his condition had deteriorated markedly in the last day or two. His legs were very swollen and he was in more pain. He was eating very little but managed to speak to his family on the telephone.

101. Officer B stayed with the man on the night of 27 May. He began his shift at the nursing home at about 8.00pm. He told my investigator that the nurses checked him every two hours during the night, at 1.30am, 3.30am and so on. He was asleep most of the night and his breathing became more laboured.

102. As the night wore on a nurse advised the officer that the man's condition had worsened and he would not regain consciousness. Nursing home staff contacted the next of kin to let them know. The officer was relieved by Officer C at about 7.20am on 28 May and left the nursing home. On the advice of the nursing home staff, Officer C telephoned the man's sister to tell her that the end of her brother's life was near. He died shortly afterwards, in the presence of Officer C and a carer at 7.50am.

103. The prison chaplain visited the nursing home later that day and a doctor from the local surgery confirmed death. The man's relatives also visited the home the same day. The prison paid for his funeral, which was held in Nuneaton on 14 June.

ISSUES

Mental health

104. Although the man's mental health was a significant concern during previous custodial sentences, his mood remained stable in both Hewell and Shrewsbury from December 2009 until his death in May 2010. Staff remarked on his good humour and "being something of a character". Whilst his physical health declined rapidly, his mental health actually seemed to stabilise. The escorting officers at the hospital noted that he was polite and respectful and got on well with the nursing staff.

105. I would like to commend the work done by the CPN A at Hewell and the CPN B at Shrewsbury to regularly review the man's mental health. As the clinical review panel note, all of the record keeping was of a high standard and the CPN at Hewell seemed to have a particularly good relationship with him, something she had developed over different custodial sentences.

106. The man discussed the pain he was experiencing with other healthcare staff at Hewell, most notably CPN A (a mental health nurse). Because physical pain is not her area of expertise, she told the investigator that, after each of her meetings with him to discuss his state of mind, she confirmed that he was scheduled to be assessed by a doctor in the near future. She had met him when he was previously held at Hewell in the summer of 2009. She told the investigator that she did not observe any obvious deterioration in his presentation when she met him again in early 2010.

107. The investigator and the clinical reviewer interviewed the CPN. The man reported physical pain symptoms to her. However, as a mental health nurse, she said that she does not have a regular opportunity to liaise with her colleagues who care for prisoners' physical health. I endorse the clinical review panel's recommendation:

    The Head of Healthcare at HMP Hewell should consider whether to hold multi-disciplinary team meetings involving primary care and in-reach staff relating to both general issues and specific prisoners.

Complaint made by the man

108. In mid-April, the man made a formal complaint to the Governor. He was unhappy that he was in pain and he said that he would contact 'the Ombudsman'. He received full responses to his complaint from a governor and also from the senior member of healthcare. He did not make any further complaints to the Governor and there are no entries in any other records to suggest that he continued to be unhappy with the treatment he received from healthcare staff.

109. The team who respond to prisoners' complaints in my office have confirmed that they did not receive a complaint from the man in April or May 2010. I understand that the Parliamentary and Health Service Ombudsman (PHSO)

did receive a complaint from him in April. However, the PHSO have been unable to release details of the complaint (or any response they might have made) to my investigator.

110. With regard to the complaint the man made to the Governor, he was undoubtedly in a great deal of pain at the time. It would very soon become clear that he was actually dying and within a couple of days he was hospitalised. I consider that the healthcare team did their best to give him appropriate pain relief, although I recognise that this was the first time that they were required to help a man whose prognosis was so poor. Shrewsbury does not have inpatient facilities and is not able to offer the sort of pain relief that patients at the end of their lives might receive elsewhere.

111. The senior member of healthcare in particular responded to the man's complaint thoughtfully and fully. I am satisfied that he, whilst unhappy when he wrote the complaint, seems to have responded well to the care he received in the weeks that followed. There is not a pattern of complaints over several weeks which would give serious cause for concern.

The man's diagnosis

112. The man originally came into custody on 4 December 2009. He remained at Hewell for the next three months. His cancer was not diagnosed during this period although he complained of hip, back and kidney pain several times. He reported passing blood in his urine and tests were completed but no problems of this nature were diagnosed. The clinical review panel have concluded that his own account was 'inaccurate'. Kidney stones were suspected and an x-ray was taken, but did not show any stones.

113. Prison Doctor C assessed the man on 12 February and thought that he was complaining of pain as a means of seeking drugs. He had a long history of drug misuse. He received warnings at Hewell for concealing his prescribed medication and then trading it in order to obtain subutex. However, the doctor told my investigator that he had not been aware of this behaviour.

114. The doctor said that he would normally read through his colleagues' previous entries in the clinical record before he assessed a patient, but could not recall if he had done so on this occasion. There is no mention of the man's attempts to 'palm' medication in his clinical record. It does not appear that nursing staff working with him were told about this pattern of behaviour. I consider that healthcare staff need to know this kind of information because it affects their assessment of whether to trust the prisoner with 'in possession' medication and whether to continue their prescription. I therefore make the following recommendation:

The Governor and the Head of Healthcare at Hewell should ensure that discipline and healthcare staff communicate effectively if a prisoner tries to supply their medication to others. Attempts to 'palm' medication should be noted in the prisoner's clinical record.

115. When he spoke to the investigator and clinical reviewer, the doctor explained that he had never met the man before the examination on 12 February. He doubted how genuine his complaint of pain was and initially decided to prescribe pain killers. The doctor thought that he wanted the medication more for its own sake rather than for its pain relieving properties. He referred to the World Health Organisation's guidelines and planned to check how well the pain relief worked.

116. The doctor explained that his intention was to consider further exploratory procedures if the man continued to report pain after taking naproxen. The doctor accepted during interview that he had not made the intended plan of action clear to other colleagues in the clinical record.

117. The doctor commented that he did not consider the possibility of an 'occult malignancy' (cancer) causing the back pain. He agreed that his presentation of pain, age and history of smoking may have indicated that such a diagnosis was a possibility. However, I am satisfied that the doctor planned to make a follow-up assessment if the man continued to report pain.

118. The doctor anticipated that the nurses handing out the prescribed pain medication would monitor the man's presentation and refer him back to a doctor if his pain did not reduce. This approach seems comparable with that which a general practitioner in the community might take. A patient who reported pain would not necessarily be sent immediately for cancer tests.

119. Further checks at the time might have revealed that the man had developed cancer. However, the clinical review panel stress that the pain the man originally reported cannot with any certainty be directly linked to his cancer.

120. The man arrived in Shrewsbury on 1 March. The senior member of healthcare told my investigator that the healthcare staff soon noticed that he looked unwell and anaemic. Within weeks he was in hospital and received a terminal diagnosis. He died less than three months later.

121. It seems to have been coincidental that the man's cancer was only diagnosed once he arrived at Shrewsbury. Although he reported pain at Hewell, there do not seem to have been any other associated symptoms such as weight loss. Within three weeks at Shrewsbury, his appearance had altered dramatically and staff remarked on how he had visibly aged since his arrival.

122. At the time the man transferred from Hewell, he had no diagnosis of cancer (only reports of pain) and there were no outstanding hospital appointments. In the circumstances, I believe that healthcare staff acted appropriately in allowing him to transfer. There was nothing remarkable about his transfer, which represented a logical progression within his sentence. He moved from Hewell (a local prison where many of the prisoners are new arrivals from court) to Shrewsbury (a training prison intended for longer term prisoners).

123. The clinical review panel stress that transferring a prisoner can interrupt the investigation of illness and subsequent diagnosis. I consider that his

continuity of care was not interrupted. A 'medical hold' (which prevents a prisoner who has forthcoming treatment scheduled from transferring) was not necessary or stipulated in this instance. The man was not undergoing treatment for a serious illness when he moved prisons.

124. Although, as the panel highlights, a prisoner's healthcare needs to be taken into account if a transfer is planned, there was nothing in the clinical record to indicate that a transfer might be inappropriate. A urine test and an x-ray had been carried out and the results were normal. Although the doctor intended to follow up on the man's assessment in mid-February, he did not write this in the notes.

125. I would encourage the Head of Healthcare at Hewell to think about the clinical review panel's recommendation about improving the handover between prison healthcare departments when a prisoner transfers. The panel suggest that a summary of ongoing treatment and health issues is prepared for the receiving prison.

126. The doctor acknowledged that he might have been more proactive in considering the possibility of cancer and taking the man's complaints of pain more seriously. However, I am satisfied that a diagnosis perhaps three weeks earlier would almost certainly not have made a difference to the man's life expectancy, given how far, how quickly and how aggressively the cancer had spread by the time it was discovered.

127. In January, discipline staff placed the man on report and took away his privileges when he refused to go to work because he said he was in too much pain. It is likely that he was indeed in some genuine distress (given how advanced the cancer was once it was diagnosed in April). However, without a diagnosis from the healthcare team, it is hard to see how discipline staff could have confidently known at the time about the extent of his pain.

Access to palliative care

128. Until recently most of the men at Shrewsbury were serving short sentences or on remand. Now that the prison has switched functions, it will predominantly hold sentenced prisoners and the average age of the men is likely to increase. This may well present problems, as the prison has no inpatient facilities and no ability to offer around the clock nursing care of the kind required by patients like him. I endorse the clinical review panel's recommendation:

The Head of Healthcare at Shrewsbury should review the facilities for intensive nursing and work with the Primary Care Trust to improve them where possible.

129. When the man died, the healthcare department did not have a palliative care policy in place. The senior member of healthcare told my investigator that he was the first example (that she knew about) of a prisoner at Shrewsbury who had required care until the end of his life. On this occasion, the speed of his

illness meant that he moved rapidly to outside hospital and then to a nursing home.

Escorts and restraints

130. The Governor was concerned that the man had only a very short time to live and should not be alone. He was also aware of his numerous previous convictions for stealing. Although he was very unwell, he was still sufficiently mobile to cause a little concern in this regard.

131. The man had no permanent address to which he could be released. His family members were unable to accommodate him. The Governor only allocated one officer to the escort, which seems a proportionate and sensible decision. Equally reasonably, the escorting officers did not wear a uniform in the nursing home and he was not handcuffed once his terminal diagnosis was known.

132. After some consideration, I am also pleased that the prison management team took the decision to keep an escorting officer with the man until he died. He was, by all accounts, grateful to the officers who sat with him. They provided him with company and were able to take him out to the garden to smoke cigarettes.

Compassionate release

133. The prison management team began the process of applying to the Ministry of Justice to have the man released on compassionate grounds. Some members of staff (the offender supervisor, the seconded probation officer and a doctor) completed assessments to move the process forward.

134. In the end, the man remained under escort and was not released from custody on compassionate grounds. The seconded probation officer had advised against release. She noted that he could not have coped on his own and would not have been able to go to all his appointments without the help of the escorting officers.

135. I am pleased that the hospital was able to locate a suitable nursing home and that the man was able to spend his last weeks in a comfortable and suitable environment. The staff who spent time with him in the home all spoke very highly of the standard of care offered there and the accommodation provided. The senior member of healthcare praised the team at the home and also thought that he was offered very good care. The clinical review panel consider that all of his palliative care needs were met by the nursing home.

136. The clinical review panel judges that the man's poor health in the last few weeks of his life meant that he presented little risk of either re-offending or harming others. They believe that release on compassionate grounds should have been given more thought. They highlight the significant cost of keeping an escort with him. They argue that the money had to be taken from the prison's healthcare budget, potentially impacting on the regime and services

offered during the financial year to other prisoners. Given the changing nature of Shrewsbury's population, the panel foresee further similar instances of this nature.

137. Although I consider that the man benefited from the presence of the escort officer in that it was both wise (because he had a very long history of offending) and humane (because the officer could help him to move around) to provide an escort, I endorse the clinical review panel's recommendations regarding release on compassionate grounds. Other prisoners in similar situations in the future may have family they can be released to or will have a different offending history. Given the changing population of the prison, the financial impact of ongoing escorts could well also be significant.

When a prisoner is receiving palliative care, all the relevant departments at Shrewsbury should give careful consideration within a multi disciplinary framework to early release on compassionate grounds.

The Governor and the Head of Healthcare at Shrewsbury should review the effects of potential rising bedwatch costs with a view to minimising any effect on the delivery of prison healthcare in general.

138. The change in the prison's function means that, sadly, it is likely that the healthcare team will treat other prisoners who require palliative care. To this end, I gather that the clinical nurse manager have been tasked with focussing on the care of older prisoners. Following the creditable example of the man's care, I am pleased to hear that the healthcare team is currently drafting a palliative care policy.

139. The senior member of healthcare spoke to my investigator about her experiences of trying to find the man somewhere appropriate to stay during his final weeks (until the nursing home accepted him). She expressed her frustration that the allocation of inpatient beds across the prison estate is not organised centrally. Instead, she found herself telephoning colleagues in a number of prisons with appropriate 24 hour healthcare facilities as far away as Norwich seeking a bed for him, to no avail. She chose the prisons on the recommendation of colleagues.

140. Until she helped the man, she had assumed that one centrally located team had overall responsibility for coordinating the allocation of inpatient beds across the entire prison estate. She thought that such an arrangement would have been an enormous help in the circumstances. Shrewsbury is not equipped to treat inpatients, and it is fortunate that the local authority made the unusually swift and thoughtful decision to locate him in a nursing home.

141. Offender Health has advised my investigator that, if a similar situation arises in the future, healthcare staff at Shrewsbury should, in the first instance, consult the regional offender health manager (ROHM) in the West Midlands. The ROHM is ultimately responsible for securing inpatient healthcare beds for prisoners such as the man. With a remit covering a large region and a

number of prisons, they are better placed to have an overview of availability and organise a transfer.

142. Although I do not make a formal recommendation, I have considered the usefulness of a central register of available inpatient beds. I appreciate that such a measure would have cost implications, as it would need to be staffed and updated each day. Nonetheless, the NOMS Population Management Unit already keeps track of each prisoner across the estate using computer systems. It may be that its function could be extended to keep Offender Health updated about the availability of healthcare beds. The increasing number of elderly prisoners requiring a high level of care means that such an innovation would no doubt be welcomed by staff such as the senior member of healthcare.

Clinical record keeping

143. The man's death was caused by cancer which had spread through his body and into his bones. The origin of the cancer was hard to determine but was thought to have begun in his lungs. I have been impressed by the standard of clinical record keeping at Shrewsbury. The progress of his treatment and the actions taken by all those involved are clearly documented. I am satisfied that any member of staff caring for him would have been able to consult the clinical record and understand the progress of his treatment. I make a point of highlighting the thorough and well written entries because, all too often, I have not found record keeping at other prisons to be of a similar standard.

144. I commend the implementation of a formal nursing care plan on 13 April. This is an expected and highly desirable step forward when a patient requires significant assistance and is facing a poor prognosis. However, it is not always the case that such action is completed promptly and documented accurately, and I am therefore keen to highlight good practice. Staff took the action in response to the man's discharge from hospital.

CONCLUSION

145. The man arrived in custody in December 2009, having only been released from prison a matter of weeks previously. He reported pain during the next three months at Hewell, but initial tests showed nothing concerning. After he arrived at Shrewsbury at the start of March 2010, his health failed rapidly and staff referred him to the local hospital. After a number of tests and admissions as an inpatient, he received a very poor prognosis. His cancer had progressed very quickly. He died less than three months after staff first became concerned about him at Shrewsbury.

146. I consider that healthcare staff at Shrewsbury cared very well for the man, particularly since they did not have previous experience of caring for terminally ill prisoners and had no inpatient facilities. The clinical review panel commend the care and concern shown by the healthcare team at Shrewsbury. The cooperation between the hospital and the prison healthcare team seems to have worked well and he was able to end his life in a nursing home where members of his family could spend time with him. I hope that the healthcare team will gain confidence from the way they helped him and use this experience going forward. Now that Shrewsbury has a larger number of older prisoners, this will probably not be the last time that they have to care for a man who faces the prospect of dying in custody.

The family's response to the draft

After the draft report of the investigation was published, the man's relatives contacted my family liaison officer. They asked to meet both her and the investigator. The meeting took place in the home of one of his brothers on 14 January 2011. Four of his siblings attended. They expressed their unhappiness about what they had learned from the draft report. In order to properly reflect their feedback, I have reproduced below the summary of the meeting which the family liaison officer sent to the family afterwards.

Summary of discussion

1. The family liaison officer began by explaining that the purpose of the visit was to help explain any aspect of the report the family were unclear about and to consider any feedback the family may have before the Ombudsman's report is made final.

<u>Coroner's Inquest</u>

2. The family were concerned the coroner's inquest may have already taken place. The investigator said he was not aware that it had and would seek to clarify this with the Coroner's office.

   Subsequent to the meeting, the Shropshire Coroner's office confirmed the inquest had not taken place and that a date had yet to be scheduled for this. The family liaison officer confirmed this in a letter to the man's brother dated 17 January 2011, along with contact details for the Coroner's office and further information about the inquest process.

<u>Inadequate healthcare</u>

3. The family feels strongly that the Prison Service, specifically HMP Hewell, failed in its duty of care to him and that the healthcare he received while in custody was not equivalent to that he would have received in the community.

4. Having considered the findings of the Ombudsman's investigation the family are deeply concerned by the lack of healthcare intervention during the three months he was at HMP Hewell. He told staff repeatedly during this period that he was experiencing pain however this does not appear to have been acted upon. Given that they think it likely he was suffering from cancer at this time, the family are upset that he was not given any stronger medication to manage this pain.

5. The family questioned the availability of doctors at Hewell, given that he appeared to have very limited interaction with the prison GPs despite his ongoing pain and discomfort. His family were highly critical that a period of about six weeks elapsed without him being seen by a doctor.

6. The family also feels strongly that the tests and referrals made were inadequate, and are concerned that healthcare staff did not explore matters

further despite his complaints of pain and discomfort. They questioned the willingness of local prisons to invest in prisoner health given they are considered a temporary location for the majority of prisoners.

Prison Doctor C

7. The family found the doctor's assessment of him a serious matter of concern. The family thinks that his crippling back pain was not taken seriously and that it was perceived by the doctor that he was merely drug seeking. Given his rapid decline in health just a few weeks later, the family believe he would have been experiencing considerable pain at this time and are angry that his symptoms were dismissed. The family commented on how isolating and frightening it would have felt for him not to be believed particularly in the restraints of a prison environment.

Refusal to attend work

8. The family believes that Hewell further failed in their duty of care by choosing to punish him for not attending work rather than investigate the cause of his refusal. He told his family he felt so unwell that he was unable to get out of bed some days, the pain he was experiencing prevented him from sleeping and he lacked the energy to attend work. The family said that, had staff explored his reluctance to work further, they would have realised that this was unusual behaviour (he had never previously shirked from prison work). In any event they believe his lack of willingness to work, coupled with his ongoing complaints of health problems should, at the very least, have prompted further referrals to healthcare.

Palming medication

9. The family questioned why he was not made to take his medication in front of nursing staff if there was an ongoing issue with palming medication.

Information sharing

10. The family were concerned that he told his Community Psychiatric Nurse on several occasions about the pain he was experiencing, yet she failed to inform other nursing staff.

    The investigator agreed information sharing between healthcare professionals could be improved. The Ombudsman has made a recommendation to improve practice in this area.

Missed hospital appointment

11. The family are concerned he was unable to attend a scheduled hospital appointment on 16 December due to a shortage of escort staff.

The investigator explained, although by no means ideal, this is not uncommon within the prison estate. On this occasion, his appointment was rescheduled and took place the following week on 23 December.

Transfer to HMP Shrewsbury

12. The family is struggling to understand why HMP Hewell did not pick up on his declining health yet he was sent for urgent tests within days of transferring to HMP Shrewsbury.

13. They are also concerned there was a delay in transferring his medical records.

    The investigator has looked into this matter and is unable to find any evidence of a delay in transferring his medical record. Paragraph 45 of the report confirms that his clinical record arrived with him when he transferred to HMP Shrewsbury.

14. For the most part, the family spoke positively about the care he received at HMP Shrewsbury, although they are concerned the Prison Service only acted when faced with no other option and questioned why the same care and attention was not afforded to him from the start.

15. The family spoke very positively about the care home and their interaction with escorting prison staff during this period.

Medical Records

16. The family asked for copies of his prison medical record.

    A copy of the man's prison medical record was sent to the family.

Internal investigation

17. The family also asked whether the Prison Service has carried out an internal investigation into the care he received and whether they could receive a copy of this.

    The Prison Service accepted the findings of the Ombudsman's independent investigation into the care he received in prison custody and, as far as we have been able to establish, is not carrying out internal investigations in individual establishments.

Lessons learned

18. The family said they felt he was denied dignity in the way he was treated, specifically at HMP Hewell. They feel it was inhumane for someone to experience such chronic pain and discomfort for three months, made worse by disbelieving healthcare professionals and inadequate and delayed treatment. The family said it is important to them to ensure lessons are

learned and that the same things are prevented from happening to another prisoner and their family.

RECOMMENDATIONS

For HMP Hewell:

1. The Head of Healthcare at HMP Hewell should consider whether to hold multi-disciplinary team meetings involving primary care and in-reach staff relating to both general issues and specific prisoners.

The prison accepted the recommendation.

2. The Governor and the Head of Healthcare at Hewell should ensure that discipline and healthcare staff communicate effectively if a prisoner tries to supply their medication to others. Attempts to 'palm' medication should be noted in the prisoner's clinical record.

The prison accepted the recommendation.

For HMP Shrewsbury:

3. The Head of Healthcare at Shrewsbury should review the facilities for intensive nursing and work with the Primary Care Trust to improve them where possible.

The prison accepted the recommendation.

4. When a prisoner is receiving palliative care, all the relevant departments at Shrewsbury should give careful consideration within a multi disciplinary framework to early release on compassionate grounds.

The prison accepted the recommendation.

5. The Governor and the Head of Healthcare at Shrewsbury should review the effects of potential rising bedwatch costs with a view to minimising any effect this may have on the delivery of prison healthcare in general.

The prison accepted the recommendation.