
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at a hospice
in July 2012, while a prisoner at HMP Belmarsh.**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is a report of an investigation into the death of a man, who died in July 2012 at a hospice while a prisoner at HMP Belmarsh. He was 68 years old. He was suffering from widespread cancer, and died from complications related to this. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust appointed to carry out a review of the man's clinical care while in custody. Staff at HMP Belmarsh cooperated with this investigation.

The man suffered from arthritis, diabetes and chronic lung disease. Skin cancer was confirmed in September 2011 and he was diagnosed with widespread cancer in July 2012.

Although some of the man's care was of a good standard, time was taken to plan for a hospice transfer and good efforts were made to support his family, the investigation also found some significant deficiencies. There were delays at the diagnostic stage, poor follow up systems and no formal end of life pathway was followed. I agree with the clinical reviewer that aspects of his clinical care were not of an equivalent standard to that which he could have expected to receive in the community. I am also concerned that early compassionate release was not given timely consideration and that risk assessments for the use of restraints when he went to hospital did not adequately take into account his age, lack of mobility and poor state of health.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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CONTENTS

Summary

The investigation process

HMP Belmarsh

Issues

Conclusion

Recommendations

SUMMARY

1. The man received a four year sentence in 2010 for indecent assault. He had been at Belmarsh since July 2010. He was a wheelchair user and lived in the inpatient unit in the healthcare centre. He was diabetic and had chronic obstructive pulmonary disorder (COPD – a serious lung condition) and osteoarthritis.
2. A suspicious skin lesion was noted in July and investigated in August 2011. However, before the results were known, he was transferred to HMP Whatton to engage in an offender behaviour programme. The man returned to Belmarsh shortly afterwards as Whatton was unable to care for his chronic conditions.
3. In September 2011, the man was diagnosed with a malignant melanoma (skin cancer) on his back. One follow-up appointment was missed by the prison, and he refused to attend a further follow up appointment. The possible consequences were discussed with him.
4. The man's diagnosis was confirmed in October 2011, and he was persuaded to attend a future appointment to have the cancerous lesion (mole), and the area around it, removed. At the beginning of December, he missed an appointment at the hospital. The records state this was because of 'a communications mix up'.
5. There are no records of any further action taken about the melanoma, although it is documented that the man did not wish to speak to the prison doctor about it.
6. In April 2012, the man began to experience bowel problems and nausea. About a month later, a hospital referral was made as colorectal cancer was suspected and he saw a consultant at the end of May. Blood samples were requested and an appointment made for 6 weeks later. Blood tests and an X-ray did not suggest any abnormalities that would have indicated cancer.
7. The man's health continued to deteriorate, but none of the results of various investigative procedures, carried out in June, alerted hospital staff to a possible cancer diagnosis at that time. A CT scan (Computerised Tomography Scan, which shows detailed images of the inside of the body) at the beginning of July, showed that he had widespread cancer.
8. On 5 July, the man was assessed for a hospice admission by a doctor from a hospice, who did not think he needed a hospice place at that time. The doctor advised the prison that he would conduct a further assessment if necessary.
9. The man developed fluid retention in his ankles and sudden onset of cold, blue painful toes on 17 and 18 July. On the 18 July, he was taken

to hospital. A doctor at the hospital decided he should be seen by a limb specialist at another hospital.

10. The man was released on temporary licence (ROTL) to hospital on 19 July 2012. The licence included the condition that he would be accompanied by an officer. The clinical team at the hospital did not treat his foot problems as he was so ill by this time. He transferred to a hospice, where he died the next day with his family present.
11. The Coroner did not require a post-mortem. The certified cause of death, given by the doctor at the hospice, stated that the man died from a lack of blood supply to the right leg caused by obstructed arteries. This was caused by complications with diabetes and widespread cancer.
12. Some of the man's care was a good standard and prison staff dealt with him compassionately. Although his family do not agree, efforts were made to ensure family members were able to visit him as much as possible and in as comfortable an environment as the prison could offer. However, some aspects of his care were not as good as that he could have expected in the community. The clinical reviewer considers some omissions could have contributed to his death. We have made recommendations about cancer referrals, use of the healthcare records system, end of life pathways, compassionate release and risk assessment for the use of restraints.

THE INVESTIGATION PROCESS

13. The Ombudsman's office was notified of the man's death on 27 July 2012. The investigator issued notices to staff and prisoners at Belmarsh about the investigation and asking anyone with relevant information to contact her. No responses were received.
14. The investigator visited Belmarsh on 3 August and met members of the management team and staff involved in the man's care. She was given copies of his medical record and relevant aspects of his prison records.
15. The local Primary Care Trust appointed a clinical reviewer to review the clinical care the man received at Belmarsh.
16. The investigator returned to Belmarsh in October to interview staff. She also interviewed one member of staff by telephone.
17. HM Coroner for the South London region was informed of the investigation. He informed this office that a post-mortem had not been carried out, and he had decided not to hold an inquest as the man's death did not occur on prison premises. He provided details of the cause of death given by the doctor at the hospice. The Coroner will be provided with a copy of this investigation for his information.
18. One of the Ombudsman's family liaison officers contacted the man's family. She told them the purpose of the investigation and invited them to raise any concerns about his care at Belmarsh. The man's wife was concerned that his diabetes, particularly that the care of his feet and legs was not managed appropriately. She believed his cancer should have been diagnosed sooner, that he did not receive appropriate pain relief and that he was inappropriately restrained when he was very ill. She also did not feel that the family were adequately supported by the prison.
19. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
20. The family received a copy of the draft report as part of the consultation period. Written representations were made in response to the findings of the investigation. The man's wife remained unhappy with a number of issues identified in the findings of the investigation. Although the comments provided have led to no significant changes to the investigation report, we have sought to clarify and provide further information where appropriate to the points raised in separate correspondence to her.

HMP BELMARSH

21. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Sussex. It holds up to 933 male prisoners.
22. Health services are commissioned by the Primary Care Trust and have been delivered by a private company since February 2011. The health care department has facilities on all the house blocks as well as in reception, the first night centre, outpatients and inpatients and provides 24 hour care,

Her Majesty's Inspectorate of Prisons (HMIP)

23. HMIP last carried out an inspection at Belmarsh in April 2011. The report noted that significant nursing staff shortages affected the prison's ability to deliver a comprehensive healthcare service. Primary care services were described as limited. The Inspectorate said that the inpatient unit needed more nursing interventions to return its focus to health and wellbeing rather than discipline. In general, there were good procedures to identify prisoners with disabilities and older prisoners, but no formal consultation took place. There was no palliative care policy, although the prison had developed links with a local palliative care organisation.

Independent Monitoring Board (IMB)

24. Each prison is monitored by an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper care and decency are maintained. The most recent report for Belmarsh covers the year to June 2011.
25. The report found that, in most respects, Belmarsh had performed well and that prisoners were treated fairly and humanely. It considered that healthcare had improved and that a previous problem of non-prioritisation of outpatient appointments had been resolved, seemingly, because of use of SystemOne (the healthcare computer system). More nursing staff were being recruited, and the Long Term Conditions Service was set to change with SystemOne being used to apply 'clinical codes' to relevant prisoners. It was considered this would allow an easily accessible model care plan for nursing staff and lead to improved care.

Previous deaths at Belmarsh

26. The man was the fourth prisoner to die of natural causes at Belmarsh in the last three years. No recommendations were made in those cases which are relevant to the circumstances of his death.

ISSUES

The diagnosis of the man's cancer

27. On 6 July 2011, Doctor A at HMP Belmarsh saw the man about a mole on his back. The doctor noted that the mole was black and 2.5 – 3cm in size. The man said it had been there for two weeks and that it was itchy and sometimes bled. The doctor did not make a dermatology referral under the two week cancer criteria rule. (When a doctor suspects that their patient might have cancer, the patient should be seen by a specialist within two weeks of the referral.) He recorded that he had asked staff to observe the lesion for any changes so that a referral to dermatology could be made if necessary. The investigator interviewed a number of healthcare staff, and none could remember the doctor telling them about the lesion or being given any instructions about monitoring for changes in its appearance. This doctor no longer works at the prison and we did not seek to interview him as the clinical reviewer did not consider there was a need for further information which was not on the medical notes.
28. On 2 August 2011, the man saw Doctor B, who examined the mole and immediately made a two week referral. He had a portion of the mole removed for analysis (a biopsy) on 15 August. Malignant melanoma (a dangerous form of skin cancer that usually gets progressively worse) was diagnosed in September 2011.
29. The clinical reviewer concludes that the man should have been referred under the two week rule by Doctor A in July 2011. He considered it would not have been sufficient to ask healthcare staff to observe the mole for changes, even if he had done so.

The Head of Healthcare should ensure that all medical staff follow the NHS guidance about the two week cancer referral rule.

Informing the man about his condition and treatment

30. It appears that the man was told that he might have cancer after the biopsy on 15 August, but the records are not clear about this. He was asked to return to the hospital on 26 September to discuss the results, but declined to attend because he did not want to be handcuffed or otherwise restrained. He signed a treatment refusal form.
31. As the missed appointment was extremely important, the Dermatology Department of the hospital contacted the prison on 28 September to discuss the possibility of setting up a telemedicine appointment by videolink. It is not recorded whether the man's diagnosis of melanoma was discussed with healthcare staff at this point. It was not possible to organise the telemedicine appointment, but the records do not explain why.

32. The healthcare department received a letter for the man, from the hospital, on 12 October 2011, which confirmed the diagnosis of malignant melanoma. A nurse and doctor explained the results to him and told him that his cancer was melanoma and that a further procedure was required. They discussed the implications with him and went through the consequences of not attending follow up appointments and accepting further treatment, which he still declined at that stage.
33. The next year, during June and July 2012, the man had further investigations at the hospital. After a CT scan in July 2012, widespread cancer was diagnosed. The disease was present in his neck, lungs, abdomen and bones.
34. The records show that on 12 July 2012, a nurse discussed the man's diagnosis with him and assured him that staff would continue to give him the best clinical care. On 17 July, he discussed all aspects of his clinical care with him. We are satisfied that once healthcare staff at the prison were aware of his condition, it was fully explained to him. He was provided with appropriate information including the implications of refusing treatment.

The man's medical appointments and treatment

35. The man had osteoarthritis, diabetes and COPD. The clinical reviewer comments that these conditions were satisfactorily managed. Specifically on the care of the man's diabetes, he says that there was good care at both Whatton and Belmarsh. His blood and urine was tested and he received an influenza vaccination.
36. The man's first hospital appointment relating to his suspected cancer was on 15 August 2011, when he had a biopsy on the mole. On 18 August, he transferred to HMP Whatton as part of his sentence progression before the results of the biopsy had been received but returned to Belmarsh within two weeks as Whatton were unable to cater for his health needs. Healthcare staff at Belmarsh did not seem to consider postponing the transfer until the outcome of the test was known and whether treatment was required. Prison Service Order 3050 specifically states "for instance, it will almost never be appropriate to transfer a patient awaiting urgent cancer referral".
37. The man was due to attend the hospital again on 9 September 2011. Although he had returned to Belmarsh on 2 September, he did not attend. No specific reason is recorded, but it appears that there was some confusion about his appointments when he transferred to Whatton and then returned to Belmarsh. The hospital offered a new appointment for 26 September. Records show that he declined to attend this appointment because he did not want to be strip searched

and handcuffed to go out to the hospital. He signed a disclaimer to this effect.

38. The man was made aware of the implications of not attending for treatment after he was told, on 12 October, that he had melanoma and needed a “wide excision and lymph node sampling”. He then spoke to his family and eventually agreed to attend future appointments.
39. On the 19 October a prison doctor recorded that liaison with the hospital was needed to make arrangements for further appointments. It is not clear if this happened. On 2 November 2011, at a long term conditions meeting, the administrator recorded that she was asked to chase the dermatology appointment. An appointment was made for 5 December, but the man missed the appointment. The medical record shows that this was because of a “communications mix up”. The investigator spoke to the Healthcare Assistant who recorded the entry. He was unable to remember anything that could clarify the situation.
40. The appointment does not appear to have been rescheduled and the records do not show why. The clinical reviewer states that it is likely that the wide excision surgical procedure would have been performed if the appointment gone ahead. He considers the subsequent failure to rearrange the appointment could have contributed to the man’s death.
41. In April 2012, the man had abdominal pain and altered bowel habits. He began having falls and slurring his speech. The records reveal that his diagnosis of a malignant melanoma was completely overlooked by healthcare staff at this time and these additional symptoms were noted in the record but not acted upon. It was not until May 2012, that he was referred to the hospital for further investigations. It is not clear whether hospital staff were alerted to the previous diagnosis of malignant melanoma.
42. By June, the records show that the man was incontinent. The investigations carried out at the hospital in May and June were inconclusive and it was not until the CT scan on 2 July that widespread cancer was found.
43. The clinical reviewer explains that SystmOne (the computerised medical record system) can be marked with a ‘read code’ which allows effective cross referencing of medical conditions. The man’s record was not marked with a ‘read code’, once the malignant melanoma was diagnosed. In addition, apart from one meeting in November 2011, there does not appear to have been any regular meetings to brief staff about his condition. This meant that healthcare staff failed to follow up this very serious diagnosis and the missed appointment on 5 December 2011. The clinical reviewer believes that the general failure to use systems properly could have contributed to the man’s death by causing a delay in the planned excision of the tumour site. We make the following recommendations:

The Head of Healthcare should ensure that all healthcare staff are trained in SystemOne and that it is used effectively to manage and communicate serious health issues, diagnoses and follow up appointments.

The Head of Healthcare should ensure that when a prisoner is diagnosed with a serious condition, there are regular, minuted multidisciplinary briefings involving all relevant healthcare staff, so that they are aware of the diagnoses, current condition and wishes about treatment.

The Governor and Head of Healthcare should ensure that there is effective information sharing so that prisoners undergoing clinical investigations for a serious condition are not transferred inappropriately.

The man's pain relief and medication

44. The man was prescribed co-codamol (for relief of mild to moderate pain) on arrival at Belmarsh, to help with the pain from his other health issues. When he began to show symptoms of cancer he was prescribed tramadol, a strong pain relief medication. This was before the diagnosis of wide spread cancer was made.
45. After his diagnosis, the man continued to take tramadol. He was assessed by a hospice doctor on 5 July 2012, who noted that he said he was not in any pain. The doctor asked the healthcare team at Belmarsh to contact him for a further assessment of the man if he began to suffer pain. There is no record that he complained of experiencing any further pain.
46. The clinical reviewer concludes that there is no evidence to suggest the management of the man's pain was not adequate.

Liaison with the man's family

47. On 5 July, three days after the man's CT scan, his wife and daughter were informed of his condition at a meeting with one of Belmarsh's managers, clinical staff and the prison family liaison officer. On 7 July, a plan for his care was drawn up. Arrangements were made for him to have extended visits with his family in a more comfortable part of the prison. His family were also given help with transport to visits.
48. The man moved from the hospital to the hospice on 26 July, and his family were with him when he died.
49. The Head of Reducing Re-Offending and a Principal Officer visited the man's family on the day he died to offer support. In line with the national policy, the prison offered a financial contribution towards the

funeral. The prison helped to produce an order of service for the funeral and liaised with the funeral directors. The family liaison officer attended the funeral.

50. We consider that the prison made good efforts to inform the man's family of his illness, to accommodate visits and to help with issues arising after his death.

The man's location

51. The man lived in the inpatient unit in the healthcare centre throughout his time at Belmarsh because of his mobility problems and chronic conditions. He remained in healthcare when he was diagnosed with a malignant melanoma and as his health deteriorated.
52. When he was diagnosed with widespread cancer in July 2012, steps were taken to have him assessed for a hospice. When he was first seen he was not considered ill enough for hospice admission.
53. On 18 July, the man became very ill with an ischaemic foot (circulatory issues) and was admitted to hospital. He transferred to another hospital later that day for specialist treatment on his foot. The clinical reviewer considers that it is likely that the ischaemic foot was part of his terminal illness. On 26 July, after further deterioration, he was moved to a hospice, where he died.
54. The man had a number of ongoing chronic conditions including diabetes, osteoarthritis and COPD and was appropriately accommodated in the healthcare centre because of his mobility problems arising from these conditions. It is recorded that he began to have frequent falls from his bed and it is not clear that any consideration was given to providing adaptations to help prevent this. Multi-disciplinary meetings, as recommended above, would have helped ensure his needs were appropriately identified and met.
55. We are satisfied that the man was assessed for hospice admission quickly after being diagnosed with widespread cancer. He was appropriately located in the healthcare centre until his hospital admission.

Compassionate Release

56. Early release on compassionate grounds (ECR) is a means by which prisoners, who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care

and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).

57. The prison told the investigator that an application for early compassionate release was not made because the man was due to have a Parole Board hearing. The prison has not been able to provide us with the date this was expected. A prison doctor told us that he was asked to prepare reports for compassionate release, but we subsequently established that the reports were for the Parole Board hearing.
58. ECR should be discussed with prisoners who have a terminal diagnosis. It appears that the prison was waiting for the outcome of the man's parole review, but we are concerned that the ECR process for him was stalled because of this. We would expect the ECR process to be actively considered at an early stage as soon as it appears a prisoner might be eligible.

The Governor should ensure that compassionate release is actively considered when a prisoner has a diagnosed terminal illness.

Palliative care plans and end of life pathway

59. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered and helps patients make choices about they are cared for towards the end of their lives. There are various examples of end of life care pathways.
60. Although a specialist palliative care referral form was completed by a doctor, there is no written record of an end of life pathway being prepared for the man. However, he was monitored for the development of pressure sores and offered emotional support by staff. He had family visits, and his pain control appears to have been monitored regularly.
61. The clinical reviewer concludes that use of a structured end of life pathway (he refers to the Macmillan Gold Standards Framework) would have allowed staff to ensure that all aspects of the man's palliative care were appropriately covered in a holistic manner.

The Head of Healthcare should ensure a recognised end of life care pathway is instigated appropriately when a prisoner is diagnosed with a terminal illness.

Restraints, security and bedwatch

62. Prisons have a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
63. The man was taken to hospital for appointments and admission on a number of occasions. Each time his risk to the public was assessed as medium but his risk of escape and other risks were assessed as low. It was also noted that he was in a wheelchair. The Head of Security at Belmarsh was unable to clarify during the course of the investigation exactly what the security arrangements were for each of these appointments. It is clear that, despite his very poor health and lack of mobility, at the minimum he was restrained by an escort chain and accompanied by two officers. (An escort chain has handcuffs at each end which are attached to the prisoner and an officer.)
64. On 18 July, when the man was taken to hospital for the final time, he was handcuffed to an officer by an escort chain and accompanied by another officer. At interview the Head of Security said that a nurse was also present. By this point, he had been diagnosed with multiple cancers, was incontinent and was in a wheelchair.
65. On 19 July, while in hospital, it is documented that the man was handcuffed to an officer. The record does not make it clear whether this was directly or by an escort chain. The family liaison log shows that the family liaison officer met family members at the hospital that day who were upset that the man was still restrained, despite his very poor health. He called the prison and asked for the restraints to be removed. The Head of Security subsequently authorised the escorting officers at the hospital to remove the restraints. He told us that he did so because at that stage he believed the man had been released on temporary licence (ROTL). The bedwatch log shows that the restraints were removed at 2.50pm on 19 July, and the ROTL licence did not begin until midnight on the 19 July.

66. When the man was released on temporary licence, he continued to be accompanied by one officer. The ROTL risk assessment indicated that his offences were against a child family member and there were concerns that his family might bring children to visit him. The assessment noted that he had not completed any work to address his offending. Social Services had previously raised concerns about his potential risk to children, although his family did not believe he had committed the offences.
67. The purpose of the risk assessment process is to ensure that decisions regarding restraints or escorts are made according to the specific risk that the individual poses at the time. The man was extremely weak, incontinent and largely immobile. It is likely that the Social Services assessment, on which the ROTL assessment draws, was done at a time when he was considerably healthier.
68. We are not satisfied that the use of restraints during the man's final admission to hospital was appropriate. The use of the restraints was not fully justified by risk assessments and did not take into account his very poor state of health. We accept that for ROTL, there were some concerns expressed about his risk to children and that Belmarsh was trying to balance the management of this risk with treating him with dignity by allowing temporary release. Nevertheless, it is still unclear whether that was based on an assessment which was kept under review and took into account his deteriorating condition and the impact this had on his risk.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

CONCLUSION

69. The man was diagnosed with a malignant melanoma in September 2011. He died in a hospice in 2012. He had widespread cancer and a number of complications.
70. The investigation found that aspects of the man's clinical care were not of an equivalent standard to that he could have expected in the community. The clinical reviewer states that there were omissions that might have ultimately contributed to his death. However, he himself also declined on one occasion to attend a hospital appointment.
71. When the man was diagnosed as terminally ill, an application for compassionate release was not properly considered. The use of restraints and escorts for hospital visits were not fully justified by risk assessments that took appropriate account of his health conditions and how this impacted on his risk.
72. However, we are satisfied that prison made good efforts to enable his family to visit the man at the end of his life and allowed him to die with dignity in a hospice.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all medical staff follow the NHS guidance about the two week cancer referral rule.

Accepted: *From December 2012, a private company assumed responsibility for the delivery of healthcare to prisoners at HMP Belmarsh. It is policy to urgently move towards the appointment of directly employed General Practitioners, clinically supervised by a lead GP and Medical Director and to cease reliance on agency medical staff.*

All medical staff are aware of the requirement to consider fast track referrals where clinically appropriate and this is being acted on. The lead GP for the Greenwich Cluster was appointed in February 2013.

2. The Head of Healthcare should ensure that all healthcare staff are trained in SystmOne and that it is used effectively to manage and communicate serious health issues, diagnoses and follow up appointments.

Accepted: *All Healthcare staff have received training on SystmOne. The appointment of permanent, directly employed GPs will ensure that clinical policies are consistently maintained and delivered including the appropriate use of Read Coding*

We will continue to develop and expand the capacity and functionality of SystmOne to support best clinical practice

We have a regular programme of training in place from specialist such as TPP to address specific training needs.

3. The Head of Healthcare should ensure that where a prisoner is diagnosed with a serious condition, there are regular, minuted multidisciplinary briefings involving all relevant healthcare staff, so that they are aware of the diagnoses, current condition and wishes regarding treatment.

Accepted: *SystmOne records regular multidisciplinary meetings at the ward management round and during frequent care plan reviews.*

It is accepted that all patients in the Inpatient Unit should be reviewed weekly at the ward management round and comprehensive multidisciplinary summaries would facilitate communication and coordination of care

We have established regular twice weekly reviews of all general patients within the Inpatient Unit, conducted by the GP.

We will establish a general ward management round.

4. The Governor and Head of Healthcare should ensure that there is effective information sharing so that prisoners undergoing clinical investigations for a serious condition are not transferred inappropriately.

Accepted: *Prisoners with medical conditions requiring active treatment are placed on medical hold. As such, these prisoners should not be routinely transferred without prior consideration of continuity of care. This process works well; however, the decision to transfer a prisoner is the responsibility of NOMS and this cannot be overridden by Healthcare staff.*

The current medical hold procedure will be reviewed at the next Patient Safety meeting.

5. The Governor should ensure that compassionate release is actively considered when a prisoner has a diagnosed terminal illness.

Accepted: *However in this particular case there were victim issues that prevented this being considered, that involved the close family; Social Services were involved in this decision. In normal circumstance this will be considered.*

6. The Head of Healthcare should ensure a recognised end of life care pathway is instigated when a prisoner is diagnosed with a terminal illness.

Accepted: *Clinical Practice for prisoners requiring palliative care is based on:-*

“NHS End of Life Care Programme. Improving end of life care” The route to success in end of life care- achieving quality in prisons and for prisoners” 3-2010

The above policy was introduced in May 2012 pending the development of a comprehensive palliative care policy

We have also developed effective joint working arrangements with the Palliative Care Service

The man was appropriately referred in June 2012 and was assessed on 5th July 2012. It was felt that immediate transfer was not clinically appropriate at that time because of the absence of significant pain and lack of clarity regarding prognosis.

7. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents, at the time.

Accepted: *In this case the Prisoner was taken to hospital for a separate medical complaint. It was once he was admitted that the Risk Assessment was reviewed. There were also victim issues involving the close family that needed to be considered closely.*