
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death a man at HMP Altcourse in August 2012**

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 the report of an investigation into the death of a man who died of a brain tumour at HMP Altcourse on 25 August 2012. He was 82 years old. I offer my sincere condolences to his family and friends.

An investigator was appointed. A clinical reviewer carried out a review of the man's clinical care at Altcourse. The prison cooperated fully with the investigation.

When the man first arrived at Altcourse on 17 July 2008, his health was already very poor. He had cancer of the prostate, angina and had undergone bladder operations. He was taking a range of medication. In prison, he received treatment for his prostate cancer and suffered from heart problems and iron deficiency anaemia. He experienced occasional dizziness, loss of balance and reported memory loss. On 27 July 2012, he was diagnosed with inoperable advanced brain cancer and he received his terminal care at Altcourse.

While the clinical reviewer has identified some concerns about whether the man was sufficiently assessed by doctors at the prison before his diagnosis, he recognises that brain tumours are very difficult to identify at an early stage. After his terminal diagnosis was made, I am satisfied that he received good care at Altcourse, at least equivalent to that he could have expected to receive in the community. Liaison with his family was good and the prison made positive efforts to help him have a dignified death.

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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SUMMARY

1. The man suffered from prostate cancer and angina and had had surgery before he arrived at Altcourse on 17 July 2008. He was assessed by a mental health nurse, a general nurse and by a doctor who noted his medical history and prescribed appropriate medication.
2. During his time at Altcourse, the man received treatment for his prostate cancer, suffered an episode of bradycardia, ischaemic heart disease, atrial fibrillation and iron deficiency anaemia. He had cataract surgery and he complained several times of dizziness, loss of balance, memory loss and that he had fallen over a number of times.
3. The man's general health deteriorated in 2012. In the early morning of 27 July, a nurse examined him in his cell after he had fallen out of bed but found no injuries. Shortly afterwards the prison doctor reviewed him because he had been having frequent falls. He said he felt unwell but had no pain, cough or any specific symptoms. The doctor found him to be confused and disorientated and had difficulty assessing him because of his restlessness. He diagnosed suspected cerebrovascular accident (stroke) and sent him to hospital.
4. At hospital, the man had a CT scan which showed that he had a brain tumour. He was admitted to hospital for further tests which resulted in a diagnosis of an inoperable primary brain tumour. He received his terminal care at Altcourse. A consultant in palliative care oversaw his treatment and liaised with and advised the prison healthcare staff as his condition continued to deteriorate, but contractual difficulties meant that the specialist support of Macmillan nurses was not provided.
5. The man was administered controlled drugs to manage his pain and was placed on the Liverpool Care Pathway, for end of life care. He died in August 2012.
6. We make recommendations about healthcare staff training needs, medical record keeping and the use of restraints.

THE INVESTIGATION PROCESS

7. This office was notified of the man's death on 25 August 2012. Notices about the investigation were issued to staff and prisoners, inviting anyone with relevant information to contact the investigator. No one came forward.
8. The investigator visited Altcourse on 3 September, and visited the healthcare centre where the man died. He spoke to the Head of Healthcare, the Deputy Governor and the prison's family liaison officer and collected the man's prison records.
9. The clinical reviewer for the local Primary Care Trust reviewed the man's clinical care at Altcourse.
10. Her Majesty's Coroner was informed of the investigation. The Coroner had decided that there was no need for a post-mortem examination as the cause of death was clear to the doctor in charge of his care. A copy of this report has been sent to the Coroner.
11. One of our family liaison officers contacted the man's son to explain the purpose of the investigation and allow his family to identify issues they wished to be considered. He was very positive about the support his family had received from the prison's family liaison officer.

HMP ALTCOURSE

12. HMP Altcourse is a category B local prison in Liverpool, receiving prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,324 sentenced and remand adult and young adult males. Altcourse is made up of seven house blocks divided into individual units. These units hold between 60 and 95 prisoners.
13. G4S runs the company that provides healthcare at the prison. There is a 12 bed in-patient facility that has a care suite, and provides 24 hour medical cover from nurses and doctors.

Previous deaths at Altcourse

14. There have been ten deaths from natural causes at Altcourse since 2008. None of the circumstances of the previous investigations is similar to those in this case.

Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons' (HMIP) last published inspection report is of a full unannounced inspection of Altcourse in January 2010. The report of a more recent inspection has yet to be published. In the 2010 report, the Inspectorate found that Altcourse was an extremely effective local prison and that healthcare services were adequate, but at the time were affected by staff shortages. Inspectors commented that "there were links with local palliative care agencies, but we were unaware of any palliative care policy".

Independent Monitoring Board (IMB)

16. In the latest report published by the IMB at Altcourse for July 2011 to June 2012, the IMB commented that, in their opinion, the general healthcare provided within the prison met the standards which prisoners could reasonably expect in the community. The IMB was concerned that an influx of prisoners with severe mental health problems was disturbing for other prisoners in the inpatient unit who were unwell, particularly those who were there for palliative care.

KEY EVENTS

17. In 2000, the man was diagnosed with prostate cancer. This was monitored by PSA testing (prostate-specific antigen, a type of protein produced almost exclusively by the prostate gland) and treated with zoladex injections (which slowly release hormones to stop the cancer growing) as and when determined by consultant urologists. He was usually injected every three months.
18. The man also suffered from coronary artery disease and, on 25 June 2007, underwent a coronary angioplasty (an operation to open narrow or blocked heart arteries) at the local hospital, when stents (a small metal mesh tube which provides support inside a coronary artery) were fitted to his left anterior descending artery and his right coronary artery.
19. According to the man's GP records he was last issued a prescription from his community doctor on 28 May 2008 with the following medication:
 - Clopidogrel (stops the blood from blocking blood vessels)
 - Ramipril (reduces blood pressure)
 - Omeprazole (treats indigestion)
 - Co-codamol 30/500 (painkiller)
 - Aspirin (thins the blood)
 - Paroxetine Hydrochloride 20mg (for depression)
 - Atorvastatin (reduces cholesterol to prevent heart attacks and strokes)
 - Atenolol (treatment for heart rhythm problems and to reduce blood pressure)
 - Tamsulosin Hydrochloride M/R Capsules 400mcg (for an enlarged prostate).
20. On 17 July 2008, the man was sentenced to nine years imprisonment for rape and sent to HMP Altcourse. At his initial health screen the mental health nurse noted he had suffered cancer of the prostate, angina and bladder operations. There was no evidence of mental illness. The nurse noted his current medications as:
 - Clopidogrel
 - Ramipril
 - Omeprazole
 - Aspirin
 - Atorvastatin
 - Atenolol
 - GTN spray (glyceryl trinitrate, to relieve angina)
 - Spironolactone (treats heart failure and high blood pressure)
 - Furosemide (a 'water' tablet which reduces blood pressure and treats heart failure)
 - Adizem (reduces blood pressure and treats chest pains)
 - Nicorandil (treatment to reduce / prevent chest pains)
 - Movicol (treatment for constipation)
 - Digoxin (used to treat atrial fibrillation)
 - Eye ointment.

21. A nurse then saw the man and referred him to a doctor. The doctor admitted him to the healthcare centre for general observation and assessment of his heart condition. The next morning, he was seen by a doctor for a general health examination. The doctor noted his previous heart surgery, prostate cancer, angina and his current medications. The doctor performed a lung function test, which was clear, and checked his teeth and hearing. The doctor noted he did not smoke and found him fit for work.
22. On 30 July, the man saw another doctor to request more eye ointment. The doctor noted he had an inflamed left conjunctiva (which lines the inside of the eyelid), and prescribed an ointment, chloramphenicol. A week later, he had his blood taken for a PSA level report, which was found to be normal. He continued to be monitored by regular PSA testing.
23. The doctor stopped the man's digoxin on 4 November after he said he had suffered from dizzy spells for five months. He received spectacles on 2 February 2009 when the optician reported a dense cataract to his right eye. He was referred to a consultant ophthalmologist and cataract surgery took place on 22 September 2009.
24. On 20 October, the man told a doctor that he had rolled out of bed twice, injuring the right side of his forehead. He also said that he had felt dizzy and faint the previous week but had not fallen down. He said that he did not have any palpitations or chest pains. The doctor found his right eye bruised and a mild bruise on the right side of his forehead and decided to check his blood, give him an ECG (electrocardiogram, which records the electrical activity of the heart) and review him with a view to decrease some of his medication if the symptoms continued. The doctor discontinued his atenol, as he was on long acting calcium channel blockers.
25. Two months later, the man stopped taking tamsulosin as he was becoming dizzy when standing after taking this medication (a known side-effect) and said he felt okay without it. Tamsulosin was reintroduced into his repeat medication on 24 May 2010. He had further cataract surgery on his left eye on 18 June and on his right eye on 5 October. A doctor stopped his tamsulosin again on 29 November as he complained of dizziness and did not wish to try an alternative.
26. The man complained of memory impairment on 31 January 2011 and was diagnosed with possible vascular dementia (caused when there is an interruption to the blood supply to the brain). An ultrasound scan of his carotid arteries (which supply the head and neck with blood) was requested but declined as the radiologist did not think that it was appropriate.
27. On 7 April 2011, the man complained of chest pains which lasted a couple of minutes. The doctor admitted him to the healthcare centre where an ECG established that he was suffering from atrial fibrillation (a disturbance of the electrical activity in heart). Blood tests then indicated that he was also anaemic and he was given iron tablets. Two days later, he was sent to hospital for further review where he was diagnosed as suffering from

pneumonia (an inflammatory condition of the lung typically caused by an infection). He was prescribed doxycycline to treat the infection.

28. The man remained in the healthcare centre for general observation until 30 April when he was found to be fit to return to his wing. On 3 June, he complained of painful knees and the doctor diagnosed osteoarthritis. He was treated with steroid injections to his knee joints.
29. On 25 July, the man saw a consultant surgeon about his anaemia. The consultant referred him for a colonoscopy (when a small camera is inserted on a flexible tube to show the inside the body). This took place on 9 August, and showed some diverticulosis (weaknesses of muscle layers in the colon wall). A biopsy was taken, which proved normal.
30. On 2 September, the man told the doctor he worried about his health which was making him depressed and sleepless. The doctor found that his mood was flat but he had no thoughts of harming himself. The doctor diagnosed depression and prescribed citalopram (an antidepressant) for 28 days.
31. The man attended the urology clinic at hospital on 20 October for his three-monthly zoladex injection. On 24 October, he complained to the prison doctor that he had a painful right third toe and following examination the doctor referred him to a consultant vascular surgeon, who saw him on 11 November. He told the consultant he had banged his toe seven weeks earlier. The consultant referred him for a scan, but this was cancelled because of his coronary stents. He was prescribed antibiotics and given an X-ray appointment.
32. On 13 January 2012, the man attended the hospital for his zoladex injection. He returned on 20 January for two appointments. He had an X-ray on his right foot which showed he had osteomyelitis (an infection of the bone) in his third right toe and regular checks were arranged. He was found to have a normal heartbeat and there was no evidence for any cardiac decompensation. He had no chest discomfort.
33. Further eye operations took place on 14 March and 23 May 2012, when he had operations to remove part of the vitreous humour of the eye, performed under general anaesthetic. He returned to hospital on 5 April for his zoladex injection.
34. The man was seen by the 'Care of Aged' staff nurse at the prison on 20 June for a chiropody review, when she cut and filed his toe nails. He told her he had no issues, he felt okay and he felt that his eyes were improving.
35. The man saw a consultant ophthalmologist again on 16 July, when the consultant performed minor eye surgery. The nurse in reception noted that he was "well in himself" when he returned to the prison. On 18 July, he had a routine cardiac review carried out by a nurse.

36. On the morning of 20 July, the man told a nurse he felt generally unwell, had been having memory loss, and was weak and unsteady on his feet. The nurse made an appointment for him to see the doctor. Later that evening he fell and scraped his arm on his bed. A nurse attended to him, and cleaned and dressed a small cut on his right arm. He was reviewed by a doctor the next day.
37. The man told the doctor he had lost his balance and that he had become gradually weaker over the last month. The doctor noted that he was now in a wheelchair as he could stand but could not walk unaided. He could lift his knees and stand on tip toe/heel with difficulty. The doctor noted he had a fairly strong grip in both hands, there appeared no gross neurological deficit, and he was calm, co-operative, alert and oriented in space and time. However, the doctor detected some lack of cognitive ability and diagnosed possible mild dementia. The doctor then decided to conduct several tests, including an echocardiogram (a test on the heart) and a full blood test.
38. Early on 23 July, the man was found on the floor of his cell by his cell mate. A nurse was called and found him sitting on his bed. He said he had no injuries from his fall but was always banging himself. He was helped back into bed and his cell mate kept an eye on him.
39. A prison doctor saw the man later that day about his frequent falls. He said he felt dizzy and was getting confused which worried him. He said he had not had any chest pain in the previous 24 hours. He scored very poorly in some mental health tests and the doctor diagnosed senile dementia. He decided to refer him to a geriatric consultant in hospital.
40. On 26 July, the prison's older person's nurse saw the man and noted that he was suffering from short term memory loss and was becoming more unsteady on his feet. She asked him to attend the healthcare centre for assessment and review by a doctor. She noted he would need help with hygiene, washing and dressing and told him he would be cared for in the healthcare centre.
41. Just after 5.00am on 27 July, the man fell out of his bed in the healthcare centre. A nurse found no new injuries and helped him back to bed. He was monitored frequently that morning until he was examined by a doctor, who noted that he said he had felt unwell but had no pain, cough or any other specific symptoms. The doctor found him to be confused, disorientated and restless and had difficulty assessing him. He diagnosed a suspected stroke and sent him to hospital. Once there, he had a CT scan which showed that he had a brain tumour. He was admitted for further tests which confirmed the diagnosis. Because of his diagnosis with a serious illness, a Prison Custody Officer (PCO) was appointed as his family liaison officer. The PCO also acted as an escorting officer at the hospital and was able to confirm the man's next of kin details and provide the hospital with this information.
42. On 29 July, the hospital informed the prison healthcare that the man's brain tumour was inoperable. At the time, his co-ordination was very poor and he could not stand unaided or walk about. The PCO informed the man's family

and arranged for his wife and son to visit him the next day. He obtained their agreement to supporting an application for the man's release on compassionate grounds. On 31 July, the level of escort was reduced to one officer and the escort chain was removed.

43. By 1 August, the man was described as comfortable and slightly improved. He said that he wanted to return to prison. On 7 August, a meeting was arranged between his consultant, the nurse manager at Altcourse, and the PCO to discuss his current condition, prognosis and future care. The consultant confirmed that he had an inoperable brain tumour and, after an assessment by an oncologist, no active treatment would be considered. He said that he was happy to discharge him back to the prison's healthcare and that he had not been referred to the palliative care team as his condition did not warrant it at that time. The nurse manager said she would order a pressure relieving mattress for him.
44. After the meeting, the nurse manager spoke at length to the man's son, explaining what care would be provided at Altcourse. She assured him that his family would be kept fully informed. He indicated he was content for Altcourse to continue to care for his father until the end of his life. The man was returned to Altcourse 10 August, where a doctor found him to be confused and disoriented, but he said he had no pain. The doctor prescribed the standard treatment of dexamethasone to reduce swelling round the tumour. Kitchen management were instructed to provide a soft diet and a beaker drinking cup to assist his fluid intake. A wheelchair and an air flow mattress were provided and two healthcare staff were assigned to help with his care.
45. The man's condition had deteriorated further the next day and a senior nurse decided that palliative care was needed. She and a doctor spoke to a doctor at a nearby hospice and a palliative care consultant for their advice about his care.
46. On 12 August, the man's mobility had deteriorated further. He could not understand when he was being asked to move his feet and legs and a doctor decided he should be nursed from his bed. A catheter was used to allow his urine to drain.
47. The doctor examined the man again on 13 August and found that his right side was weak and he had very poor grip in his right hand. He was confused, intermittently agitated and found it difficult to take his oral medication. The doctor liaised with the palliative care consultant, who thought that the disease had progressed. He advised stopping non-essential medication, to give injectable medication and said that he would not recommend CPR if he had a cardiac arrest.
48. The prison's family liaison officer discussed this with the man's family that day and they agreed that resuscitation should not be attempted if he stopped breathing or his heart stopped. A 'Do Not Resuscitate' instruction was put in place and his medication was amended. His family also informed the PCO

that they did not wish to pursue parole or compassionate release. They considered he was receiving a better level of care at Altcourse than he would anywhere else, so did not believe there would be any benefit in early release.

49. A nurse liaised with the Macmillan care team (specialist nurses who offer advice, information and support to people with cancer) who agreed to meet and discuss the man's needs. However, they did not attend a meeting arranged at Altcourse on 14 August.
50. A doctor examined the man on 17 August and diagnosed bronchopneumonia. He was not breathless, was still very confused, but said he was in any pain. The doctor then discussed his case with the palliative care consultant, who recommended that if necessary he should be given midazolam for agitation, hyoscine hydrobromide for chest secretions, diamorphine for pain and dyspnoea, and cyclizine for nausea. The consultant did not recommend artificial hydration or feeding if his intake tailed off, as this was part of the dying process, but to give regular mouth care and occasional sips instead.
51. The man's two sons visited their father the same day and the doctor explained their father's state of health in detail. They also met the Chaplain and asked the PCO to notify his eldest son, when their father died.
52. The man became more restless, agitated and slightly distressed on 18 August and was administered midazolam and hyoscine hydrobromide by injection. He appeared more settled and slept peacefully. The next day it was noted that he was only able to tolerate small amounts of fluid but did not appear breathless, chesty, agitated or in pain. He was visited by his grandchildren and he appeared to brighten up. The chaplain attended to give him the anointing of the sick.
53. A doctor noted a slow deterioration of the man's condition on 20 August. His swallowing was poor and he was gagging on his oral medication, having difficulty expelling secretions, and was drowsier but did not appear to be in pain. The doctor ceased all fluids and diet due to risk of aspiration and a suction machine was used to help him.
54. A multidisciplinary meeting was held to discuss the man, attended by a doctor, palliative care consultant, a healthcare manager, a senior nurse and a deputy senior nurse. The consultant told the meeting that the Macmillan nurses had refused to come to Altcourse as he had asked, as there were 'organisational issues' which prevented them from coming to the prison. This meant it was not practical to set up a syringe driver (a small pump used to gradually administer small amounts of medication to patients over a period of time) as the nurses at Altcourse were not trained in its use.
55. The Liverpool Care Pathway for the Dying (LCP, a UK care pathway covering palliative care options for patients in the final days or hours of life, which helps doctors and nurses provide quality end-of-life care) was begun. The man appeared settled and comfortable and his medication was regularly reviewed by the doctor. He received regular visits from his family.

56. In late August, the man was unable to communicate properly although he could say yes and no and indicated he was not in any pain. The next day, a doctor noted that he appeared to have deteriorated significantly, was semi-conscious and only responded to verbal commands intermittently. He appeared comfortable and not in any pain. The doctor briefed the man's sons again. The PCO explained what would happen when their father died and told them that the prison would pay for the funeral expenses. They said they appreciated that their father was comfortable and were very happy with the care he was receiving at Altcourse.
57. One morning a few days later, a nurse, who was observing the man from outside his room, informed another nurse that she thought he had died. The nurses checked for a pulse, but could not find one. The nurse informed the duty operations manager and a doctor, who then came to the prison. When the doctor arrived he noted there were no signs of life and certified death at 6.37am.
58. Shortly after, the prison activated its death in custody contingency plan. A hot debrief was held at 8.00am and no issues were raised.
59. The man's family were informed of his death by the PCO. The chaplain informed a prisoner who was a close friend of the man and had visited him daily when he was in the inpatient unit, and ensured he was supported. Notices of his death were sent to prisoners and staff and support from the care team and counselling was offered to anyone who felt the need for them. A memorial service for him was held at the prison.

ISSUES

Diagnosis of the man's brain tumour

60. The clinical reviewer has noted that before 27 July 2012, when the man was diagnosed with a brain tumour, there were a number of occasions when he presented with symptoms that could have indicated a brain tumour. It does not appear from his medical records that these were followed up either by taking a detailed history or appropriate examination. The clinical reviewer notes that this should have been expected in a primary healthcare setting.
61. Brain cancers are rare and are often difficult to diagnose early especially if the patient does not display common symptoms of increased intra-cranial pressure such as headaches, nausea and vomiting, or problems with the central nervous system like weakness of muscles, reduced sensation, poor eye coordination, or effects on eye sight. On several occasions, it was noted in the man's medical records that he felt dizzy and weak. While these are symptoms common to many illnesses, they could indicate a brain tumour.
62. Because of the difficulty of making an early diagnosis, the clinical reviewer notes that it is hard to determine from the man's medical records if an earlier diagnosis of brain cancer could have been made. However, his symptoms were not followed by an in-depth review of his medical history or a comprehensive physical examination by a doctor. The General Medical Council's document "Good Medical Practice" (2006) states that good clinical care includes an adequate assessment of the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary, examining the patient.
63. In the view of the clinical reviewer, the medical team did not assess the man comprehensively, or, if they did, they did not document these assessments properly. Although it is not apparent that this would have led to an earlier diagnosis of a brain tumour, the clinical reviewer believes that this aspect of his care was not as good as it should have been. He recommends that each doctor who dealt with him should review their dealings with him to see if there are any training needs. We make the following recommendation:

The Head of Healthcare should ensure that potential training needs of doctors identified by this report are assessed and addressed.

The man's treatment and palliative care

64. After the diagnosis of untreatable advanced brain cancer was made on 27 July 2012, the clinical reviewer considered that the health care team at Altcourse responded very well. He found no difference in the standard of care that the man received in prison and the care he would have received in the community. The reviewer noted that he was prescribed the appropriate medication in advance which allowed good symptom control and a peaceful death. He also noted that Altcourse had good links to the local hospice, which provided support and advice about palliative care, and also discussed his care

with his family appropriately. At the end of his life the Liverpool pathway was appropriately used.

65. However, the reviewer also noted that the Macmillan nursing team would not come to Altcourse to review the man at Altcourse. This was apparently for contractual reasons. While he received good palliative care at Altcourse, it is a concern that prisoners at Altcourse suffering from cancer might be denied the specialist expertise and support of Macmillan nurses.

The Director should ensure there are appropriate arrangements for Macmillan nurses or an equivalent service to support prisoners suffering from cancer.

Medication

66. The man's healthcare records indicate that he was prescribed a number of medications at Altcourse when he arrived (specifically furosemide, spironolactone, adizem, nicorandil and digoxin) which were not prescribed by his GP. In particular, digoxin is prescribed to treat atrial fibrillation but there is no evidence in his medical records before he arrived at Altcourse that he was ever diagnosed with this condition. There is no evidence in his medical records from Altcourse to show if or how his medication was confirmed with his GP after he arrived. It is important that a prisoner's existing prescriptions are checked when they arrive, and that the reasons for prescribing any other medication are clearly recorded in the medical record. We make the following recommendation:

The Head of Healthcare should ensure that prisoner's medication is checked against their GP records when they arrive at Altcourse, and that the reasons for prescribing any medication are clearly entered in the medical record.

Clinical record keeping

67. The clinical reviewer found several shortcomings with clinical record keeping at Altcourse. These included the way his previous medical history had been summarised in the medical record, and that staff at Altcourse had not used standard terminology for recording his symptoms. He believes that this made it more difficult to identify the chronic nature of some of his symptoms. The reviewer also found that another prisoner's information was entered in the man's records, with obvious implications for both prisoners. These issues are discussed in greater depth in the clinical review. It is important that information is recorded correctly in medical records, and we make the following recommendation:

The Head of Healthcare should ensure that all important information is accurately recorded in prisoners' medical records.

Use of restraints

68. The Prison Service has 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 handcuffing 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.
69. The man was taken to hospital on 27 July 2012, and was escorted by two prison officers and restrained using an escort chain. This was the same level of restraint and escort used as on previous occasions when the assessments had noted that he remained a risk to children because of the nature of his offence. It seems unlikely that an 82 year old man in his state of health would have needed restraints to prevent his escape from two prison officer escorts. When he went to hospital on 27 July, this was less than a week after the doctor had noted he was now in a wheelchair and could stand but could not walk unaided. He subsequently had a least two falls and on 26 July was again reported to be unsteady on his feet. He was being sent to hospital with a suspected stroke. In these circumstances, we do not consider that his risk was properly assessed so as to justify the use of restraints.
70. In assessing risk, it is important that all relevant factors are taken into account, and that the risk assessments are based on current presentation and not on historical factors. We make the following recommendation:

The Director and Head of Healthcare should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that potential training needs of doctors identified by this report are assessed and addressed.

NOMS accepted the recommendation and commented: All Doctors (General Practitioners) will be advised by the lead Doctor and Practice Manager that when a patient presents three times with recurrent symptoms they must be fully explored.

[A prison doctor] to complete a module on recognition of Red Flag symptoms—management and diagnosis

[A prison doctor] to complete an event analysis and to present findings to Head of Healthcare and Director of Secure Healthcare

2. The Director should ensure there are appropriate arrangements for Macmillan nurses or an equivalent service to support prisoners suffering from cancer.

NOMS accepted the recommendation and commented: Issue raised at PHPB in October 2012 and January 2013. Commissioner to take forward on behalf of Altcourse Healthcare

Meeting on 26 Feb 2013 to explore arrangements for palliative care equivalent to McMillan

3. The Head of Healthcare should ensure that prisoner's medication is checked against their GP records when they arrive at Altcourse, and that the reasons for prescribing any medication are clearly entered in the medical record.

NOMS accepted the recommendation and commented: Current policy is we check medication prescribed with an offender when he comes in to custody. Upon confirmation from GP and ensuring safe and appropriate medication is continued, otherwise a medication review will take place. Medication is audited by Pharmacist on a monthly basis.

4. The Head of Healthcare should ensure that all important information is accurately recorded in prisoners' medical records.

NOMS accepted the recommendation and commented: SystmOne is in place and ensures information is contained in a central place should an offender/patient be transferred from one establishment to another.

New/remand offenders information relies on the offenders self-reporting and accessing healthcare. Information shared from offenders is completed on the admission template on SystmOne and secondary screening is completed within 72 hours. Challenges remain in obtaining information from GPs

nationally this will be further addressed in the new national healthcare structure

5. The Director and Head of Healthcare should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

NOMS accepted the recommendation and commented: Security as part of the Prison Security risk assessment links with Healthcare to identify any physical or mental health needs, which may affect escort. Healthcare supports security healthcare cannot dictate to security on risk assessments but act as an advisory.