PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at hospital in December 2012, while a prisoner at HMP Lewes.

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 in December 2012, while a prisoner at HMP Lewes. He was 62 years old and died of metastatic pancreatic cancer. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care during his time in custody. HMP Lewes cooperated fully with the investigation.

The man first reported symptoms of abdominal pain and loss of appetite to a member of healthcare staff on 7 November 2012, when he asked to see a doctor. He was not given an appointment until 22 November. A complaint he made about the delay was poorly handled but eventually the appointment was brought forward to 20 November, almost two weeks after his initial request. A range of blood tests were conducted and, on 11 December, a doctor suspected he had cancer but did not make an urgent referral for him to be seen by a hospital specialist. However, he became increasingly ill that day and he was admitted to hospital the next morning, where he was diagnosed with untreatable cancer and was told he did not have long to live.

The clinical reviewer notes that pancreatic cancer is very difficult to diagnose and that, by the time it is diagnosed, it is often too late to be treated. While I am satisfied that it would have been difficult to diagnose the man's condition sooner, I am concerned about the delay in him being seen by a doctor in November. Although this would not apparently have affected the outcome for him, GPs should make urgent referrals to specialists whenever cancer is suspected. I am also concerned that, when he was taken to hospital, he was restrained on the basis of an inadequate risk assessment. Almost simultaneous with his final illness the Parole Board had decided to direct his release. It is sad that, due to difficulties with his licence conditions and the Christmas holidays, his release was not able to be effected before his 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 **June 2013**

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SUMMARY

1. The man was sentenced to life imprisonment in July 1995. In 2010, he transferred to the Britannia House resettlement unit at HMP Norwich and was released on temporary licence (ROTL) on 17 February 2011. However, he failed to return and handed himself in at a police station three days later. On 21 February, he was taken to HMP Lewes where he hold the nurse who conducted his reception health screen that he had a history of alcohol abuse but had no other health concerns.

2. The man next saw healthcare staff on 7 November 2012, when he was suffering from stomach and abdominal pain. He was given a non-urgent appointment to see a doctor on 22 November. On 10 November, he made a formal written complaint about the delay but this was not dealt with by the healthcare department until 19 November, when the appointment was brought forward to the next day.

3. On 20 November, a doctor saw the man and prescribed heartburn and indigestion medication, paracetamol and a muscle relaxant often given to people with irritable bowel syndrome. Another doctor saw him on 5 December and thought that he might have a trapped nerve but asked for blood tests to eliminate any underlying conditions.

4. The next day, a doctor reviewed the test results, some of which were abnormal. The doctor examined the man on 11 December and found him to be jaundiced, with his liver enlarged. The doctor thought he might have a cancerous tumour but he did not make an urgent referral under the NHS rules for patients with suspected cancer to be seen by a specialist within two weeks. Instead, he recommended that he should have a scan. There is no record that a referral for this scan was made.

5. At approximately 7.00pm on the evening of 11 December, an officer asked a nurse to examine the man as he was in a lot of pain. The nurse found he was noticeably jaundiced and his blood pressure and pulse were raised. She wanted to send him to hospital but a doctor noted that he had not had his pain relief that day and considered his main problem was pain. It also appears that the doctor was concerned about the logistical difficulty of a hospital admission from prison at night. He was admitted to the prison inpatient healthcare unit overnight for observation.

6. Another doctor re-examined the man the next morning, 12 December, and he was admitted to the hospital later that day. He remained at the hospital and was diagnosed with advanced metastatic pancreatic cancer on 19 December. Until his diagnosis, he was restrained by an escort chain. His condition deteriorated rapidly and he died at the hospital several days later.

7. The man received generally good care at the prison. Pancreatic cancer is very difficult to diagnose and is usually too late to treat after it has been diagnosed. There is no evidence that anything could have been done to prevent his death. However, we are concerned about the delay before he

saw the doctor in November 2012. Although this did not affect his eventual diagnosis as he was admitted to hospital the next day, we consider that he should have had an urgent referral to see a cancer specialist on 11 December. We also believe it would have been preferable for him to have been admitted to hospital on the evening of 11 December, rather than waiting until the next day. When he was admitted to hospital the initial risk assessment to determine the appropriate level of security did not take into account all the available information about his risk.

THE INVESTIGATION PROCESS

8. After the Ombudsman was notified of the man's death, his prison files and medical records were obtained from the prison. Notices were issued announcing the investigation to staff and prisoners at HMP Lewes asking anyone with information about his death to contact the investigator. No one came forward.

9. The investigator visited Lewes on 15 February and interviewed the Head of Healthcare, one of the prison doctors, a prison officer and a senior officer. She also interviewed a prisoner at Lewes. She returned to the prison on 21 February to interview a nurse. Another doctor provided a written statement.

10. A clinical reviewer reviewed the man's clinical care in prison.

11. A copy of this report has been sent to the Coroner.

12. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation process and to ask if there were any relevant issues she wished the investigation to cover. She had no specific concerns about his treatment, but mentioned the delay in her brother seeing the prison doctor when he first complained of abdominal pain. This issue is addressed in the report.

13. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, medical appointments, liaison with his family, his location and security arrangements, whether compassionate release was considered and palliative care arrangements.

14. The Ombudsman's family liaison officer contacted the man's sister, his nominated next of kin. The family liaison officer explained the investigation process and asked if she would like a copy of the draft report. After discussing the structure and content of the report she decided not to receive a copy believing that it would be too upsetting to read.

HMP LEWES

15. HMP Lewes is a local prison which serves the courts of East and West Sussex and holds up to 723 remanded and sentenced adults, and young offenders on remand. Health services are provided by a NHS Foundation Trust, except GP and dentistry services. GP services are provided by a private company. There is an inpatient unit with 19 beds.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) conducted an unannounced inspection of Lewes in November 2012. HMIP found that overall the healthcare provision at the prison was reasonably good. Inspectors noted that most prisoners were able to see a GP within a week, but prisoners on L wing (where the man lived) and M wing waited up to 16 days for a GP appointment, which was unacceptable. The inpatient unit was described as old and austere and overdue for refurbishment. Most of the inpatients had mental health problems. Inspectors noted that external hospital appointments were rarely cancelled and there was good access and links to the nearby hospital.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Lewes covers the year to 31 January 2012. In the section on healthcare, the IMB noted that the aim of the healthcare team was to provide the same level of treatment and care to those in prison as they would receive in the community. The IMB considered that in some cases, particularly with mental health, the care was better than that provided in the community.

Previous deaths in custody

18. The man's was the seventh death at Lewes since 2009. There has been a further death since. None of the circumstances of those deaths are relevant to this investigation.

ISSUES

The diagnosis of the man's terminal illness

19. The man received a life sentence in 1995. He was twice released on licence but was recalled to prison after breaching the terms of the licence. In 2011, he was released on temporary licence but again failed to comply with the licence conditions. After he handed himself into police, he was transferred to HMP Lewes on 21 February 2011.

20. That evening, a nurse saw the man for a reception health screen. He told her that he had a history of alcohol abuse and had collapsed the day before his arrest (19 February) after drinking a large amount of vodka and taking valium. He had been admitted to hospital but discharged himself later that day. His blood pressure was high (163/96) and he weighed 9st 6lb. A prison doctor reviewed him later.

21. The man had little contact with healthcare staff between February 2011 and November 2012, apart from some minor ailments such as psoriasis and toothache. On 7 November 2012, he told a pharmacy technician, who was issuing medication and holding a triage session on the wing, that he had stomach and abdominal pain. The technician made an entry in his medical notes that "[pain] doesn't seem to be related to digestion". He was given a GP appointment for 22 November.

22. On 10 November, the man made a written complaint that 16 days was too long to wait for an appointment. On 16 November, he saw a nurse on the wing and said he had continuous right-sided kidney and lower abdominal pain. He gave a urine sample but nothing abnormal was detected. She noted in his medical record that his next GP appointment had been booked for 22 November but that he had spoken to the Governor who had advised him to get an earlier appointment. She left a message for a colleague to discuss the matter with a GP. The appointment was brought forward to 19 November. He did not attend that appointment and there is no record that he was informed of it.

23. The man's written complaint was not dealt with by the healthcare department until 19 November, nine days after he sent it. He then received a reply apologising for the delay. A new appointment was made for the next day.

24. Doctor A saw the man on 20 November, when he said he had continuous abdominal and loin pain and a reduced appetite. His weight was recorded as 9st 4lb, only 2lbs less than February 2011. He was prescribed gastrocote (used for heartburn and indigestion), paracetamol and buscopan, a muscle relaxant often given to people with irritable bowel syndrome. He was given a further appointment for 27 November so the doctor could review him.

25. On 23 November, the man saw the pharmacy technician on the wing and told him that the medication was making his symptoms worse. He asked for

ibuprofen, but the technician declined to give this as it can cause stomach irritation.

26. The man did not attend his review with the doctor on 27 November. The reasons for this are not recorded. It is not clear whether healthcare staff rescheduled the appointment or if he requested another appointment but, on 5 December, Doctor B saw him when he said he was still suffering from abdominal pain. He told the doctor that he had not opened his bowels for 12 days. The doctor examined his abdomen; found that his pain was "reproduced by palpating [feeling with the hands and fingertips]". The doctor thought that he might have a trapped nerve. A urine sample was tested and again nothing abnormal was detected. His weight was again reported to be stable. A blood sample was taken for testing.

27. Doctor C reviewed the results of the blood tests the next day, 6 December. The results showed that CRP (C-reactive protein) and ESR (erythrocyte sedimentation rate) levels were raised. This blood test is used to identify infection and potential malignant disease, showing inflammation in the body. The man's ESR level was 34 (normal is 0-15), and his CRP was 133 (normal 0-5). His alanine amino transferase, alkaline phosphatase (both are liver enzymes) and white blood cell count were also raised. The doctor noted that these abnormal blood test results indicated that he needed to be seen again.

28. Doctor C examined the man on the morning of 11 December and noted that he was jaundiced and that his abdomen felt full. He thought that his liver might be enlarged. He told the investigator that, because of the blood tests and the man's presentation, he thought he might have a cancerous tumour. He noted that the man should be referred for a scan, but there is no record that this was done. He did not refer him urgently under the NHS procedures for patients with suspected cancer to be seen by a specialist within two weeks.

29. At approximately 7.00pm that evening, an officer on the man's wing called the healthcare department and asked a nurse to come and see the man as he was concerned he looked unwell. He told the nurse that he was in a lot of pain and had found blood in his urine that day. His blood pressure was high at 174/98 and his pulse was 124 (normal levels range from 60 – 100).

30. The nurse took the man to the healthcare department and Doctor C examined him. The doctor noted that he needed an urgent scan and would soon need to be admitted to hospital to relieve his jaundice. However, he did not think that he needed to be admitted urgently that night. The nurse later noted in the medical notes that the doctor had told her that she was not to send him to hospital. She arranged for him to be monitored in the inpatient unit overnight.

31. The next morning, 12 December, Doctor B visited the inpatient unit as usual. He saw the man at 9.36am and found that his abdomen was distended, his liver enlarged and he was noticeably jaundiced. He arranged for him to go to hospital that morning. At hospital he underwent blood tests, an ultrasound and CT scan of the chest and abdomen.

32. The man remained in hospital and, on 19 December, was diagnosed with advanced metastatic pancreatic cancer. (Metastatic cancer is cancer that has spread from the place where it first started to another place in the body.) The cancer had also spread to his liver.

33. The clinical reviewer commented in his clinical review that pancreatic cancer can be particularly challenging to diagnose as the symptoms can be non-specific. By the time it is diagnosed, it is often too late to be treated. He said that he would not have expected a sooner diagnosis. However, he would have expected the man to have been referred under the 'two week rule' as soon as cancer was suspected. We agree this should be standard practice, but note that in this case it did not delay his diagnosis as he went to hospital the next day and was seen more quickly than he would have been under an urgent two week referral. We make the following recommendation:

The Head of Healthcare should ensure that doctors at Lewes follow the NHS cancer referral guidelines issued by the National Institute for Health and Clinical Excellence (NICE).

The man's medical appointments and treatment

34. On 7 November 2012, the pharmacy technician made an appointment for the man to see a doctor on 22 November while he was issuing medication. He was not a qualified nurse but the Head of Healthcare said that this was in line with the prison's triage system. The nurse told the investigator that issuing medication at the same time as triage could be challenging. She said that she often found that she did not have sufficient time or privacy to triage thoroughly. Sometimes she said that she went to see prisoners later because they were reluctant to discuss medical issues while waiting in the line. The November 2012 inspection of Lewes also noted that there was little privacy and the opportunity for triage on the wings was compromised by lack of time and inadequate treatment rooms.

35. The clinical reviewer said that he was surprised that the man was given an appointment for two weeks later, given his symptoms and would have expected an appointment to have been made within a couple of days. He also thought that the triage system was unsatisfactory as there was a lack of confidentiality and that the member of healthcare staff also had to issue medication at the same time. He suggested that prisoners should only be asked to request an appointment at the medication hatch, unless their problem was extremely urgent. A qualified nurse (and not a pharmacy technician) should then triage the request in a more confidential setting later. We agree and make the following recommendation:

The Head of Healthcare should ensure that triage is undertaken in appropriate privacy by a trained nurse as a separate duty from issuing medication.

36. The Head of Healthcare agreed that prisoners on some wings had to wait longer than they should to see a GP. Before the man's death, GP appointments were booked by wing and prisoners for A or C wing were seen first and prisoners from L (his wing) and M wings last. The Inspectorate was also critical that some prisoners from L and M wings waited for up to 16 days for GP appointments. The Head of Healthcare said that the process had now changed. GP appointments were still booked by wings, but the order was rotated so that prisoners on L and M wings would not always have to wait longest. The clinical reviewer commented that this did not ensure there are sufficient appointments to meet need. We make the following recommendation:

The Head of Healthcare should ensure that there is equity of access to a GP and that there are sufficient appointments available to meet prisoners' needs.

37. On 10 November, the man made a complaint to the healthcare department about having to wait 16 days for a GP appointment. There is no record of the complaint being dealt with in the healthcare department until 19 November. The Head of Healthcare said that healthcare complaints are collected from the wings each day, scanned onto the medical record and given to the relevant person to answer. There is no central healthcare complaints log so it is not possible to determine when his complaint was received, only the date it was scanned. After the complaint was scanned it was answered the next day and dealt with appropriately. We make the following recommendation:

The Head of Healthcare should introduce a system to ensure and record that healthcare complaints are dealt with quickly.

Informing the man about his condition and treatment

38. The man was not diagnosed with cancer while he was at the prison. Doctor C wrote in the man's medical record on 11 December that he suspected pancreatic cancer but there is no record that he discussed his suspicions with him at that stage. On 19 December, when he was an inpatient at hospital, he was told that he had incurable pancreatic cancer, that he did not have much time to live and that he would be offered palliative care to help his discomfort and pain. We are satisfied that he was informed as soon as his condition was diagnosed.

The man's pain relief and medication

39. On 20 November 2012, Doctor A prescribed gastrocote (for heartburn and indigestion), paracetamol and buscopan (a muscle relaxant to relieve the pain of irritable bowel symptom and abdomen pain). On 5 December, after the man complained of continued pain, Doctor B prescribed diclofenac, a pain killer with anti-inflammatory properties. Later, as he presented with increased pain, Doctor C prescribed tramadol on 11 December, an opiate painkiller used to treat moderate to severe pain. The clinical reviewer noted that the use of

tramadol was appropriate, although he thought that a higher dose could have been used.

40. The man was admitted to hospital the next day, 12 December. After being diagnosed with terminal cancer on 19 December, he was fitted with a syringe driver, used to give pain relief. He was given diamorphine (used for chronic and severe pain), levomepromazine (used in palliative care forpain, restlessness, anxiety and nausea) and dexamethasone (an anti-inflammatory drug). The clinical reviewer was satisfied that the medication he was given in hospital was appropriate.

The man's location

41. On the evening of 11 December, a nurse thought that the man should go to hospital and noted in his record that this is what he wanted. However, Doctor C considered that his condition was similar to when he had seen him earlier, and that he did not need to be admitted to hospital. The nurse told the investigator that she had made the doctor fully aware of the symptoms and that the decision was taken out of her hands.

42. Doctor C told the investigator that, although he suspected that the man had cancer, he considered that his main problem that night was pain. He said that he had not received the tramadol prescribed to him earlier that day and he thought that this was what he needed. He also said that, due to prison staffing levels, it was easier to admit someone to hospital during the day rather than at night.

43. The doctor told the investigator that the man was seen by Doctor B the next morning who reviewed his location. He said it was his usual practice to brief the doctor working the next day to ask them to check any new inpatient. Doctor B had no recollection of being briefed by him, but was asked to see the man by healthcare staff, at which time he decided that he needed to go to hospital. He was admitted to hospital later that day, and remained there until he died.

44. While there is a question whether it would have been preferable for the man to be admitted to hospital on the night of 11 December, that was a matter of clinical judgement for Doctor C which we do not second guess. There is nothing to suggest that staying in the prison's inpatient unit was an inappropriate location. The progress of his illness was very rapid and we are satisfied that an appropriate decision was made to transfer him to hospital on 12 December.

45. While in hospital, the man asked to be transferred to a hospice. Unfortunately, he died before a place there became available.

Restraints, security and bed watch

46. The Prison Service has a duty to protect the public when escorting prisoners to hospital, while treating prisoners with humanity and dignity. The level of

restraints used should be appropriate to all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

47. 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 the 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. The judgement also required that risks during stays in hospital needed to be assessed separately from travel to and from prison and should be reviewed regularly during a hospital stay or when circumstances changed.

48. When the man was admitted to hospital on 12 December 2012, he was escorted by two prison officers. His escort risk assessment showed that he was deemed to be low risk of escape and he was restrained using a single handcuff, which was replaced by an escort chain during medical examination and treatment. The escorting officers were advised that restraints could only be removed for emergency treatment. As part of the escort risk assessment, his failure to comply with ROTL failure in 2011 was highlighted but his risk of escape was regarded as low. No medical opinion was given about how his condition impacted on his risk of escape.

49. The risk assessment did not take into account that on 4 December, the Parole Board had directed the man's release subject to him being transferred to an alcohol treatment centre. The decision was sent to the prison on 10 December, two days before he was transferred to hospital. A Senior Officer (SO) from the prison's security department, who completed the assessment, told the investigator that he was unaware of the Parole Board's decision. Nevertheless, his risk of escape had been assessed as low. It is not clear why it was considered that restraints were necessary for a very ill prisoner whose risk of escape was judged to be low and who was escorted by two officers.

50. The man's escort risk assessment was not reviewed until 19 December, after he had received his final diagnosis of untreatable cancer. The Parole Board's decision was noted in this risk assessment. The bedwatch was reduced to one officer and restraints were removed at 2.30pm that day.

51. Because of the proximity of the Parole Board's decision to direct the man's release and the decision to send him to hospital, it is understandable that the information was not considered in time for the initial risk assessment. However, he remained in restraints for a further week. The Parole Board's decision should have been taken into account before that and his rapidly deteriorating condition should have been kept under review. It is not apparent that all appropriate information was taken into account when making the decision about the use of restraints. We make the following recommendation:

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.

Palliative care plans

52. After receiving his cancer diagnosis the man was visited by the hospital palliative care team on a number of occasions. Palliative care drugs were issued using a syringe driver. He later agreed with the palliative care team and his oncologist that a DNAR (do not resuscitate order) should be completed. The clinical reviewer was satisfied that he received excellent care from the palliative care team at the hospital.

Compassionate release

53. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill 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 and prisoners are usually expected to have less than three months to live. The criteria include 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).

54. The man's situation was complicated by the fact that he was due to be released from prison. His release on licence had been delayed for some time until an appropriate alcohol rehabilitation centre and funding for his treatment could be identified. However, at a panel held on 4 December 2012, the Parole Board directed his release. His licence conditions required him to reside at an ANA treatment centre in Portsmouth. Had he not been admitted to hospital on 12 December, it is likely that he would have been released shortly after the receipt of the Parole Board's decision.

55. As the man's release had already been agreed, subject to conditions, an application for compassionate release was not pursued. Instead, after he was admitted to hospital on 12 December, a member of the pre-release team, the Head of Offender Management and the Probation Manager at Lewes asked the Parole Board to change the licence conditions to allow the location of his release to be "to reside at an address as directed by your supervising officer". This would have allowed him to be released to the hospital and eventually transferred to a hospice.

56. However, on 21 December 2012, this change of licence conditions was challenged by the man's offender supervisor, who contacted the Parole Board to say that he did not support a change of licence address to facilitate immediate release. Although he was aware of the man's diagnosis and had

spoken to hospital staff, he said that he was concerned that his release to hospital had not been risk assessed and there had been no liaison with the police, MAPPA or the Probation Trust. Because of the objection, the Parole Board panel Chair had to consult the other two panel members but was unable to do so because of the Christmas holiday. A decision would not be possible until 27 December, even though it was known that he possibly had only a few days to live.

57. We consider it was reasonable in the circumstances for prison staff to ask the Parole Board to change the licence conditions to allow release rather than pursuing an application for compassionate release which would have been likely to take longer. This was a pragmatic and sensible approach. The intervention of the man's offender supervisor, when he had only days to live, was unfortunate and a similar intervention in an application for compassionate release would also have meant that it would have been unlikely to succeed without further information. It is important that individual opinion about risk is taken into account but the timing of the offender supervisor's opinion which was at odds with that of the Head of Offender Management and the Probation Manager at the prison was regrettable. The man was regarded as suitable for release for alcohol treatment when he was fit, so it is difficult to see how he could be regarded as a higher risk when he was dying in hospital. As these circumstances are highly unlikely to be repeated we make no recommendation about the matter.

Liaison with the man's family

58. Hospital records indicated that the man refused permission for hospital staff to contact his family on 18 and 21 December. He said that he would phone his sister himself to let her know he was in hospital. He did so and his sister visited him in hospital three times before he died.

59. The man's sister lived in London and stayed at a hotel near the hospital. The escort records show that she visited the hospital at 11.50am on the day he died. He died at 3.16pm that day after she had left. The escort officers' records indicate that the prison was unable to contact her by telephone when he died as they only had her home phone number in London. The hospital staff contacted the hotel where she was staying, but she was not in her room so they left a message asking her to contact the hospital. The escort officers asked hospital staff to obtain her mobile telephone number when she called so that the prison could contact her.

60. At 5.50pm, the man's sister contacted the hospital and was told that her brother had died. The prison's family liaison officer contacted her on 27 December to introduce herself and offer support. The prison assisted with funeral arrangements. He was cremated on 10 January 2013.

61. When the man's cancer was diagnosed on 19 December he wanted to let his sister know himself. It is possible that he would not have wanted anyone from the prison to contact her at that stage. However, his sister subsequently visited him in hospital three times without any formal prison liaison with her.

Prison Service Instruction (PSI) 64/2011 requires prisons to put in place arrangements "for an appropriate member of staff to engage with the next of kin…of prisoners who are either terminally or seriously ill". The PSI also expects prisons to break the news of a prisoner's death to a prisoner's next of kin in person as soon as possible. Had a member of staff been appointed to liaise with her before her brother's death, this would have allowed them to have obtained her contact details and discuss with her how she wanted to be informed of his death if she was not present at the time. We make the following recommendation:

The Governor should ensure, in line with PSI 64/2011 that an appropriate member of staff is appointed to engage with the next of kin of terminally or seriously ill prisoners.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that doctors at Lewes follow the NHS cancer referral guidelines issued by the National Institute for Health and Clinical Excellence (NICE).

   The National Offender Management Service responded with,

   Accepted - To develop a system for monitoring that GPs follow the NHS cancer referral guidelines. **Target date for completion 30/09/13**

2. The Head of Healthcare should ensure that triage is undertaken in appropriate privacy by a trained nurse as a separate duty from issuing medication.

   The National Offender Management Service responded with,

   Accepted - To develop a system for nurses to provide triage after they have issued medication. **Target date for completion 30/09/13**

3. The Head of Healthcare should ensure that there is equity of access to a GP and that there are sufficient appointments available to meet prisoners' needs.

   The National Offender Management Service responded with,

   Accepted – Change GP appointment times so there is equity of access across all wings. **Target date for completion – 31/05/13 (Completed)**

   Ensure there are sufficient GP appointments by monitoring waiting times. The Head of Healthcare monitors GP waiting times. The number of GP sessions is based on what was commissioned. If the waiting times become too long the Head of Healthcare would discuss with commissioners. **Target date for completion 30/06/13 (Completed)**

4. The Head of Healthcare should introduce a system to ensure and record that healthcare complaints are dealt with quickly.

   The National Offender Management Service responded with,

   Accepted - Develop a complaints tracking system so that effective monitoring of complaints and response timescales can take place.

   The complaints tracking system is managed by the admin team. When we receive a complaint from a prisoner we now record the date the complaint was made, the date it was received in healthcare, the date it was allocated to a manager for a response and the date the response was sent. This allows the Head of Healthcare to have much closer monitoring of complaints timescales. **Target date for completion 31/05/13 (Completed)**

5. 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.

   The National Offender Management Service responded with,

   Accepted - A protocol has been introduced to ensure that any change of identified risk, is communicated by the OMU, to the Security Department, at the earliest opportunity. This information will form part of the dynamic risk assessment. **Target date for completion 15/5/13 (Completed).**
   Local information sharing policy supplied.

6. The Governor should ensure, in line with PSI 64/2011 that an appropriate member of staff is appointed to engage with the next of kin of terminally or seriously ill prisoners.

   The National Offender Management Service responded with,

   Accepted - The appointment of a FLO in accordance with PSI 64/2011 will be carried out at the earliest opportunity. **Target date for completion 15/5/13 (Completed)**