Investigation into the circumstances surrounding the death of a prisoner at HMP Pentonville on 2 October 2005

Report by the Prisons and Probation Ombudsman for England and Wales

June 2006

This is the report of an investigation into the death of a prisoner who died in the Healthcare Centre at HMP Pentonville on 2 October 2005. The man had been diagnosed with terminal lung cancer earlier in the year. In September, he had returned from hospital to Pentonville, where his condition rapidly deteriorated.

The man was 54 years old when he died. In January 2006, an inquest into his death found that his death was due to natural causes.

I would like to extend my condolences to the prisoner's family and friends for their loss.

One of my Investigators conducted this investigation. I am grateful to the Islington Primary Care Trust for undertaking a clinical review into the man's care and treatment. I would also like to thank the Governor of Pentonville, and his staff, for their help and co-operation during this investigation.

I would like here publicly to commend those members of Pentonville staff who were involved in the care of the prisoner. They demonstrated sensitivity, flexibility, and compassion both to the prisoner and his family in what were difficult and emotional circumstances. However, as the clinical review highlights, there are also some lessons to be learned in caring for those who are terminally ill in prison.

Stephen Shaw
Prisons and Probation Ombudsman **June 2006**

CONTENTS

Summary

The investigation process

The prisoner

HMP Pentonville

Events prior to the prisoner's death

Events after the prisoner's death

Clinical review and post mortem

Findings and conclusions

Recommendations and good practice

Annexes:

- **A. Clinical review by the Islington Primary Care Trust**

Summary

At approximately 9.55am on 2 October, the prisoner was provisionally pronounced dead by healthcare staff in the Healthcare Centre at HMP Pentonville. He was 54 years old when he died and had been suffering with terminal lung cancer. A post mortem was not carried out on the direction of HM Coroner, as the man's condition was known and the outcome anticipated.

The prisoner had been remanded in custody in December 2004. In February 2005, he was sentenced by Crown Court to two years imprisonment.

In early May 2005, the prisoner was referred to the hospital having complained of severe pain across his shoulders and neck. He had also coughed up blood. It was suspected at the time that he might have contracted tuberculosis and he was subsequently allocated to the prison's Healthcare Centre, and special nursing procedures were implemented, whilst clinical investigations continued. Further investigation at the hospital determined that in fact the prisoner had lung cancer.

Following his diagnosis, the man received radiotherapy and chemotherapy treatment as an inpatient in hospital. On 26 June, he was told that the cancer therapy was not effective and that the cancer had spread. He was advised he only had a few months to live. In view of this prognosis, the prison prepared a report on the prisoner that would be sent as a submission the Secretary of State in the final stages of his life asking for consideration to be given to the man's release on compassionate grounds. However, the request was not submitted by the prison because the prisoner's condition deteriorated so rapidly that there was no time to submit the report or to arrange for his release before his death.

In early September, the prisoner was discharged from hospital back to the prison. Arrangements were made between the prison and the hospital for him to receive palliative care in the Healthcare Centre. Preliminary arrangements were also in hand to transfer the prisoner to a local hospice with support from officers in civilian clothes. However, the man's rapid deterioration was of such concern to medical staff that this was not considered to be in his best interests. Indeed, it was the prisoner's wish to die in the Healthcare Centre.

As the prisoner continued to deteriorate, the prison arranged for members of his family to visit and stay with him at his bedside. His brother, who was also his next of kin, was present when he died. The family were very grateful for the way in which Pentonville afforded the prisoner compassion, care and dignity in the last days of his life.

The clinical review by the Islington Primary Care Trust has highlighted a number of administrative deficiencies in respect of maintaining clear, concise and continuous medical records. However, the review has also confirmed that the prisoner was given a level of care equal to, if not better than, he

would have received in the wider community. I hope this finding, which coincides with what the family themselves told my investigator and with my own layman's judgement, offers comfort and reassurance to the man's friends and relatives.

The investigation process

1. The investigation was opened at HMP Pentonville on 6 October 2005 when my investigator attended the prison. Notices were issued to staff and prisoners informing them about the investigation and giving them the opportunity to speak with the investigator. No responses were received.

2. The Governor and his staff produced the prisoner's core record, his Medical Record and a number of other documents for examination.

3. Islington Primary Care Trust was contacted so that they could conduct a clinical review into the care and treatment that the prisoner received in the prison. The review is attached to this report as an annex.

4. One of my Family Liaison Officers, contacted the prisoner's family by telephone on 26 October. He offered the family an opportunity to meet with him and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that the family would like explored and addressed. The family were very appreciative of the care and treatment afforded to the prisoner.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and the scope of my investigation. In early January 2006, the inquest took place into the man's death and established that he died of natural causes. Upon completion, my final report will be sent to the Coroner for his information.

The prisoner

6. The man was born in 1951. At the age of 14, he left school with no qualifications and came to the United Kingdom in search of work. He was employed as a builder, but had to give up work about ten years ago because of failing health. The prisoner came from a large family and remained in contact with them. The family is described as very close knit.

7. The prisoner was a single man at the time of his sentence but according to prison records had two grown up children. Although some contact was maintained with his children, they were not aware of the nature of his offences.

8. The man had been a heavy drinker and this problem escalated following the death of his brother. At the time of his arrest in December 2004, the prisoner was voluntarily undergoing alcohol detoxification in East London.

9. This was not the prisoner's first experience of prison. He had a criminal history going back to 1968 for a variety of offences that included crimes of violence.

HMP Pentonville

10. Pentonville is a Victorian prison. Its primary function is to serve the courts of north London. The prison holds prisoners on remand for all Magistrates' Courts and Crown Courts within the area, as well as prisoners who have been convicted and sentenced. The establishment has an operational capacity (maximum crowded capacity) of 1,175 prisoners.

11. An inspection report for 2005 from HM Chief Inspector of Prisons said that, although there was a new and impressive Healthcare facility at Pentonville, primary care was limited and some prisoners did not have confidence in the system. The report found that Nursing Plans were poor, as was health promotion.

Events prior to the prisoner's death

12. The prisoner was remanded into custody at Pentonville in December 2004. It was established during the routine health screen that day that he had a history of ischemic heart disease and had suffered three heart attacks. It was also established that in 1995 he had been treated for a brain tumour. The man also had diabetes that was controlled by diet, and was a heavy smoker. At the time of his reception, he was described as in reasonably good health.

13. In February 2005, the prisoner received a two year sentence. Having spent a considerable time on remand, he was due to be released from prison in December 2005. Whilst at Pentonville, he was not considered to be a discipline problem and had not been subject to any adjudication (disciplinary hearings) in respect of his conduct.

14. On 14 March, the clinical record indicates that the prisoner complained of pains in the right side of his neck and left shoulder.

15. On 20 April, the prisoner was seen again by Healthcare, complaining of pain in his neck and across his shoulders. He found it hard to move. At the time, it was believed that the problem was muscoskeletal in nature and involved trapped nerves. The prisoner was prescribed analgesics and referred for blood tests and an x-ray.

16. On 28 April, he stated that he was 'coughing blood'. He continued to suffer with pain across his shoulders and his spine. An x-ray was arranged in order to eliminate tuberculosis (TB). The x-ray indicated a shadow on the left side of his chest which could have been indicative of TB. For that reason, the prisoner was moved to an isolation cell in the Healthcare Centre. In light of his suspected condition, Pentonville also implemented barrier nursing procedures and nursing staff wore gloves and masks when dealing with the prisoner.

17. On 4 May, he attended the hospital for tests under prison escort and restraint. He returned to his isolation cell at Pentonville that same day.

18. On 13 May, he attended the Chest Clinic at hospital where he was told by the consultant that he had cancer of the lung. He returned to Pentonville and remained in Healthcare, receiving painkillers for the pain in his neck, shoulders and spine. In the meantime, arrangements were made for him to attend the local hospital in order to receive treatment for his cancer.

19. On 26 May, he was admitted to hospital. In compliance with the prison's security procedures, he was subject to constant bed watch by prison staff. While he remained mobile and in light of his offence, it was vital to retain public confidence in the criminal justice system and balance security needs against those of the individual. Throughout his stay in hospital, the

prisoner was not considered and did not present a discipline problem to the staff.

20. On 8 June, in a letter from the hospital to Pentonville, it was stated that the man's cancer had spread. A scan had detected secondary cancer in the cervical, thoracic and lumber spine regions. In light of this development, he required urgent radiotherapy in order to prevent spinal compression and early neurological damage. The prisoner was given approximately six months to live at this stage. The consultant treating him was concerned that, in light of this prognosis, he should receive appropriate palliative care. The consultant spoke to the Governor at Pentonville, asking him to consider early release for the prisoner on compassionate grounds.

21. Throughout June and July, he was still an inpatient at the hospital where he had been receiving radiotherapy and chemotherapy. However, by late August, the treatment was deemed to be ineffective and unlikely to prolong his life. The prisoner was given about three months to live. His mobility was greatly reduced and he was mainly confined to a wheelchair. He was also given special permission by the medical staff to smoke in the hospital grounds.

22. The deputy governor confirmed that Release on Temporary Licence (ROTL) was not considered appropriate because of the nature of the prisoner's offence and the fact that he still had some mobility. The man's consultant advised the deputy governor and the Head of Healthcare that he was not ill enough at this stage to transfer to a hospice.

23. The deputy governor asked the prison's operations manager to prepare a report to the Secretary of State, asking him to consider compassionate early release of the prisoner on medical grounds (under section 30 of the Crime (Sentences) Act 1977). The report was completed on 23 August, in anticipation of the man's discharge from hospital. However, the deputy governor believed that release could only be considered when the prisoner entered the final stages of his life. When this was known, the report would have been submitted for the Secretary of State's consideration. The deputy governor stated that this was difficult to determine in the prisoner's case - even in late August as he was still mobile. Indeed, there was a view that the man might well live to his release date. The deputy governor was mindful of the fine balance between the prisoner's needs and the public interest in not interfering with the intentions of the sentencing court.

24. Meanwhile, on 12 September, th e prisoner was discharged from the hospital back to the Healthcare Centre at Pentonville. A letter written by a Palliative Care Consultant records that his condition was deteriorating and that he was fully aware of this. Whilst in hospital, he had been receiving regular visits from the prison chaplain as well as from his family. The prisoner derived much comfort from these visits. It was the prisoner's wish to go back to Ireland to be close to his family, but he recognised that this was unlikely to happen.

25. On 13 September, the prisoner was seen at Pentonville by an Occupational Therapist from the hospital. Following the visit, an elevated bed was ordered that would allow for better comfort and assistance with breathing. More pillows were provided to support the prisoner. It was noted in the medical record that he was able to use a wheelchair and that he was able to breath unaided. The man continued to suffer pain in his shoulders and neck and this pain was adequately controlled with appropriate medication. The prisoner also continued to enjoy smoking.

26. On 15 September, the medical record indicates that he was experiencing some shortness of breath and a lot of pain in his neck and shoulders. A soft collar was given to him for psychological and physiological support. He was also taking Ensure protein drinks to supplement his diet.

27. By 16 September, the prisoner's condition had significantly deteriorated, so much so that moving him was considered to be against his best interests. Consequently, the report asking for release on compassionate grounds was never forwarded for consideration. The prisoner had also stated that he wanted to remain in the prison's Healthcare Centre until his death.

28. On 16 September, a spinal chair was ordered for the man by the Healthcare Centre. At this time, initial enquiries were made for him to transfer to a hospice. A placement in the hospice would have allowed greater access for his family in his final days. However, as a serving prisoner, he would have been initially subject to bed watch by prison officers until such time that a request for his compassionate release had been granted. The family felt that the prisoner's presence at the hospice would bring unwanted and unwelcome attention. Because of these sensitivities, this option was eventually discounted.

29. On 16 September, he was moved to a room in the Healthcare Centre where an elevated, electrical bed had been placed. Initially, the bed did not work properly because of electrical problems, but he was made comfortable. The following week, the prisoner was to be formally reviewed by the palliative care team from the hospital. In the meantime, healthcare staff at Pentonville were encouraged to contact the palliative care team if they were not sure how to manage the prisoner. A pain chart was started for him.

30. On 17 September, the medical record indicates that the prisoner was reasonably comfortable and was pleased to learn that his sister would be visiting him shortly. He was comfortable in talking to staff about his illness and prison life. The medical record indicates that he was in good spirits all things considered.

31. On 18 September, the medical record shows that healthcare staff were concerned about the prisoner's habit of chain smoking and his proximity to the oxygen cylinder in his cell. He was encouraged to smoke outside his cell as he had the use of a wheelchair.

32. On 20 September, some members of his family visited him in Pentonville. The visit was described as emotional and tearful, with family members acknowledging his condition and coming to terms with the fact that he had only a short time to live. During the day, and in consultation with the prisoner, a form was signed by the Palliative Care Consultant and a nurse indicating that, in the event of losing consciousness, no efforts were to be made to resuscitate him. The visit by the Palliative Care Consultant that day indicated that the prisoner had been managing reasonably well since being discharged from hospital. However, he had been experiencing increasing pains in his neck and shoulders and increasing weakness in his limbs. The man was also beginning to experience some difficulty in passing urine and required nursing care primarily in bed.

33. On 21 September, the medical record indicates that during the morning, the man had been coughing up fresh blood. During the afternoon, he was told by the Governor that attempts were being made to transfer him to a hospice although because of the restrictions placed on him, he would need to be escorted at all times by two prison officers in compliance with standing security procedures. The prisoner stated that he was receiving good care and attention in the Healthcare Centre. It was also noted in the medical record that he did not want to have a shower as this process could cause respiratory distress. He appeared to be paler in complexion and had developed an audible wheeze. The man was given the use of a nebuliser in the early evening to assist his breathing. He also had the use of oxygen in his cell. It was also noted by healthcare staff that he was smoking less.

34. On 22 September, the man's skin on his lower chest looked mottled. His physical condition continued to deteriorate and he was beginning to lose the strength in his limbs. In consultation with his next of kin, it was decided that in the circumstances it was not in his interests or safety to move him to a hospice.

35. On 23 September, the medical record indicates that he was displaying signs of cyanosis (a bluish colouration of the skin, due to a lack of oxygen) and also suffering bouts of apnea (cessation of breathing). A memo dated the same day was signed by the prison Governor, the prison's lead GP and acting head of healthcare. It stated that, in agreement and with the advice of the nursing staff assigned to the prisoner and the Palliative Care Consultant, in the event of a significant bleed from his lungs, a single injection of Morphine Sulphate and Midazolam could be given to him. This would ease any pain or distress suffered by him associated with a major inter-thoracic bleed. This procedure was agreed with the prisoner.

36. On 24 September, the man's respiratory levels were recorded at 14-16 breaths per minute. He was described as very weak, but still orientated in his thought. During the afternoon, it was noted that his breathing pattern had changed and that no air was entering his left lung. He was also struggling to get air into his right lung and the man felt as though his lungs

were stiffening. In light of his extreme difficulty in breathing, the prisoner was asked if he would like to see a priest. He declined the offer. The duty governor was made aware of his deteriorating condition. He was made as comfortable as possible by Healthcare staff. Later on in the day, the prisoner received a visitor and was able to have a cigarette. He later told staff that he was glad to have the chance to speak openly with his visitor and to make his peace.

37. On 25 September, the medical record notes that the man's oxygen saturation level was 92% on room air with 18-20 breaths per minute recorded. His pain was under control, although he was experiencing episodes of apnea, as well as confusion. It was also noted that the prisoner was sleeping for long periods of time. He had developed pressure sores which necessitated him being turned regularly in bed by the nursing staff. By this time, he was finding it very difficult to eat solid foods and in view of this, pureed and soft foods were offered. He was also given Ensure Plus drinks. He developed a liking for the vanilla flavoured variety.

38. In the early evening of 26 September, a prayer service was arranged in the Healthcare Centre for him and other prisoners.

39. On 27 September, the medical record indicates that the prisoner took some breakfast and three cups of fluid. He was also able to have a cigarette. He was still complaining of pain across his shoulders and had developed a pressure sore on his neck that was treated.

40. On 28 September, the man was visited by his family. His respirations were recorded at 14-20 breaths per minute and he was using oxygen through nasal prongs. He was able to tolerate fluids with assistance and was washed in bed by nursing staff. Because of the pain he was experiencing in his shoulders, he was given a strong analgesic. The prisoner stated that he was comfortable.

41. At about 4am on 29 September, the man woke up and experienced a severe episode of shortness of breath. He appeared to be in a confused and disorientated state of mind. However, despite his breathing difficulties, the medical record indicates that he was insistent on being able to smoke.

42. At 4pm that day, the medical record indicates that the prisoner was commenced on a syringe driver containing 200mg of Morphine and 5mg of Midazolam. He was visited by the palliative care team during the day. He did not raise any concerns about his care or treatment. The medical record also notes that he was drinking good amounts of water but was passing little urine. He was not able or willing to eat any meals.

43. At 7.50pm on 29 September, the Healthcare Centre received a telephone call from the man's daughter, stating that she would like to visit her father. She also stated that some members of the family would also like to visit

him in order to pay their last respects to him. The prison made the necessary arrangements. The medical record indicates that the prisoner had an unsettled night. He was still showing signs of confusion and disorientation, however his pain was controlled and he was reasonably comfortable.

44. In the meantime, the prison had been in contact with the Coroner's Office seeking advice on what action to take when the man passed away. The prison was advised that his death should be treated as a death in custody and that the prison's contingency plan for such events should be followed accordingly.

45. At about 9.10am on 30 September, the Healthcare Centre asked for the prisoner's nominated next of kin, to be contacted. The prisoner's vital signs had deteriorated overnight and he was again showing signs of cyanosis. A member of the Prison Chaplaincy team, also attended the man's cell and spoke with him. The Chaplain's visit appeared to give the prisoner some comfort and solace. The Chaplain spent a significant proportion of the day at the man's bedside. The medical record states that the prisoner was not able to smoke and declined oxygen.

46. At about 6.35pm on 30 September, the man's daughter and partner visited him. He was asleep for most of the time and, although his daughter was very tearful, she appeared to become more settled after visiting her father. The medical record indicates that at 9pm the prisoner still had visitors at his bedside. He was not in any sign of distress and his oxygen levels were recorded at 88%. Photographs of his family were left at his bedside by his visitors.

47. On 1 October, the man was still showing signs of cyanosis. Although unable to drink, he was taking fluid from foam swabs. It was noted that his heart rate was weaker and that his complexion had paled. He was reacting to voice commands but unable to co-ordinate his responses with his eyes. At 8.30am, his brother was present at his bedside. By 11.30am, his pulse was described as weak. A fan was placed in his cell to keep him cool. With the consent of the prison, a member of his family took possession of his watch, ring, radio and glasses for safe keeping. By 8.20pm, the medical record indicates that the man was experiencing severe breathing difficulties. The prison made prompt and sensitive arrangements to enable the prisoner's brother and sister to remain with him throughout the night. His fluid intake was very poor by this point, and his lips were extremely dry so they were being moistened regularly by staff.

48. At about 6.30am on 2 October, the man's breathing was described as very laboured, his pulse was irregular and he had a slightly raised temperature.

49. By 8am, the prisoner's breathing was described as very shallow. His brother was advised by Healthcare staff to remain at his brother's bedside,

as it was felt that the prisoner's breathing pattern would not be sustained for much longer.

50. At 9.55am on 2 October, the man was provisionally pronounced dead by Healthcare staff. No attempts were made to resuscitate him in compliance with the order signed on 21 September. At about 10.20am, he was officially pronounced dead by a doctor.

Events after the prisoner's death

51. Following his death, and with the consent of the duty governor, the prisoner's brother took legal possession of his brother's personal affects. These included a box of photographs that that had been left at the man's bedside and a crucifix that belonged to the prison Chaplain. The Chaplain had given permission for the prisoner to be buried with it. A set of prison-issued rosary beads was also taken. Permission had been granted for the prisoner's brother to stay with the body until the police and undertakers had arrived.

52. The man's funeral took place in October 2005. According to the family, the prison had offered financial support towards the cost of the funeral but this was declined by the family. The Prison Service was not represented at the funeral.

53. In a telephone conversation with my Family Liaison Officer, the prisoner's family were full of praise for the efforts of the Healthcare staff at Pentonville. A member of the family who works in a hospice has said that the man received compassionate care and attention whilst he was in the final stages of his life.

54. On 22 November, my investigator received a copy of a letter from the Coroner's Office. The letter, dated 8 November, and signed by members of the prisoner's family, said that he received an excellent level of care whilst at Pentonville with one to one nursing. Indeed, the family are convinced that he received a better level of care compared to that he would have received in the wider community.

55. In January 2006, the Coroner's inquest took place and it was recorded that the prisoner died of natural causes. The family have not raised any concerns in regard to his care or treatment.

Clinical review and post mortem

56. The Coroner's Office confirmed that they were made aware of the prisoner's condition by the prison. Because the outcome had been anticipated, a post mortem was not carried out.

57. The clinical review into the care and treatment provided to the prisoner has highlighted a number of issues in regard to the maintenance of medical notes and care plans with a view to ensuring that they are legible, clear, concise, consistent, continuous, appropriate and robust. The review has also highlighted the need to ensure that palliative care staff are given quick and easy access to a prisoner, particularly in circumstances where such visits are unannounced. The review has also established that, where specific medication is required for the purpose of pain control, Healthcare should make adequate arrangements for it to be stored on site for use by the palliative care team.

58. The clinical review concludes that the diagnosis of the man's cancer was appropriate and timely. The review also suggests that the care provided to him by the prison healthcare team and the palliative care team in the Healthcare Centre was reasonable, appropriate and exceeded the expected level of care that would be available to the wider community.

Findings and conclusions

59. The was initially suspected of having contracted tuberculosis. The prison implemented a barrier nursing policy and kept the prisoner in isolation pending further investigation. Following x-rays and scans, it was soon discovered that he had cancer of the lungs and secondary cancers that required urgent treatment in hospital.

60. Despite radiotherapy and chemotherapy, the treatment was not deemed to be prolonging the prisoner's life and he was discharged from hospital back to the Healthcare Centre for palliative care in September. Although terminally ill, he was not considered ill enough to be transferred to a hospice at that stage. In August, he was given approximately three months to live. The man's health continued to deteriorate rapidly and would have done so in any environment.

61. In anticipation of the prisoner's death, the prison prepared a report dated 23 August that was to be submitted to the Secretary of State seeking permission to release him on compassionate grounds. The report was to be forwarded for consideration in the final stages of his life. The timing of the submission to the Secretary of State took into account the needs of the prisoner and the wider public interest in the integrity of sentencing decisions. However, the deputy governor who requested the report stated that it was very difficult to establish exactly how long the prisoner had to live at the time that the report was compiled. Unfortunately, from 16 September, the prisoner's condition deteriorated with such rapidity that there was little time to submit the report and to obtain the Secretary of State's authority to release him. In any event, his condition was considered to be so grave after 16 September that moving him was considered to be against his interests. It was also the prisoner's wish to remain in the Healthcare Centre. I make no criticism of the prison, in that decisions relating to compassionate release are necessarily inexact. However, consideration might have been given in submitting the report prior to the man's discharge from hospital, particularly when it was known that he had only months to live. In response to my draft report the Prison Service has stated that the prisoner's condition deteriorated rapidly, an unforeseen development that rendered prison management unable to continue with the process of early release.

62. Some attempts had been made in September to transfer the man to a hospice where he would be close to his family. Although this would have afforded better access to him, the family felt that he might attract unwanted attention as the man would initially have been subject to bedwatch by prison officers (until such time as authority had been received from the Secretary of State for him to be released on compassionate grounds). A Release on Temporary Licence (ROTL) was not considered appropriate because of the nature of the prisoner's offence.

63. On discharge from hospital on 12 September, the prisoner's care was taken up by the prison healthcare team who were supported by the

hospital's Palliative Care Consultant and specialist nursing team. The man was moved to a large cell that was equipped with a special bed and oxygen cylinder. He was reviewed regularly by the prison doctor as well as the Palliative Care Consultant.

64. As the prisoner's condition deteriorated, provision was made by the prison for his immediate family to visit him in the Healthcare Centre. These visits were arranged outside of normal visiting hours and gave family members a high degree of space, quality time and dignity to say their goodbyes. There is no doubt that the man derived a great deal of inner peace, comfort and solace from such visits. He died with his brother at his bedside. The family were full of praise for the way in which the Prison Service in conjunction with the hospital managed his condition. His family are convinced that he received a good level of care and treatment that was at least equal to, if not better, than that in the wider community. I share these views. Staff at Pentonville are to be commended for their sensitivity, compassion and flexibility. I am sure the Governor will wish to share my comments with the staff concerned and with the wider prison community.

65. The prisoner received an appropriate level of care and treatment whilst in prison. Indeed, the clinical review notes that the treatment afforded to him was that which might have been expected in society at large. However, the clinical review has highlighted a number of issues that should be addressed, including ensuring that record keeping is in compliance with the Nursing and Midwifery Council's standards. The Prison Service has subsequently accepted most of the recommendations that I have made.

Recommendations

- ***Operational***

In line with the prison's security procedures, consideration should be given to developing a local policy to ensure quick and easy access to a prisoner by palliative care staff, particularly when visits are unannounced or arranged at short notice.

This recommendation has been accepted by the Prison Service.

In the event that larger than normal quantities of pain relief medication are required for a prisoner with palliative care needs, the Healthcare Manager should ensure that adequate stocks are available and secured on the premises.

This recommendation has been accepted by the Prison Service.

Where specific medication is required for the purpose of pain control, the prison should make arrangements for these to be stored on site for use by the palliative care team.

This recommendation has been accepted for review by the Prison Service.

The Healthcare Manager should ensure that record keeping complies with the Nursing and Midwifery Council's standards for record keeping in order to maintain consistent, continuous and legible records with a view to providing a concise and accurate overview of a patient's care in compliance with the Nursing and Midwifery Council's standards for record keeping.

This recommendation has been accepted by the Prison Service.

- ***Recommendations from the clinical review***

Whilst the panel acknowledge the delivery of care given to the prisoner, exceeded that which he could have expected to have received in the wider community, speedier and timelier planning for the place of care could have been more effectively managed so that the man could have received palliative care in a hospice.

Not accepted – the Prison Service acknowledges that the delivery of care was 'reasonable, appropriate and equitable to that of the wider community'. Further, the prisoner's condition deteriorated rapidly, an unforeseen development that rendered prison management unable to continue with the due processes that are in place to enable full review of healthcare options.

The prison healthcare team need to review and agree a standardised set of healthcare records that can be used for every prisoner. Particular attention

needs to be given to developing a continuous record that can be used for in-patients in the healthcare unit that includes robustly and regularly reviewing nursing care plans.

This recommendation has been accepted by the Prison Service.

Standards of record keeping need to be reviewed as part of the appraisal process for all healthcare staff including GPs.

This recommendation has been accepted by the Prison Service.

Record keeping audits are considered to be good practice and the panel strongly recommend that all healthcare staff participate in a record keeping audit at least once a year.

This recommendation has been accepted by the Prison Service

The panel remain concerned that the prisoner remained shackled for the duration of his treatment and care whilst an in-patient at hospital. It is suggested that the procedure for restraining individuals that are known to have a terminal illness is reviewed.

Not accepted – Shackles is an emotive term. The handcuffs were removed from the prisoner while he was at the hospital. While he remained mobile and in the light of his offence, it was vital to retain public confidence in the Criminal Justice System and balance security needs against those of the individual.

The wishes of the prisoner's family for a prison family liaison officer and a family room to be available for similar future situations to be given some consideration.

This recommendation has been accepted for review by the Prison Service.

Good practice

Staff at Pentonville should be commended for the flexibility, care and compassion shown to the prisoner and his family in what were sensitive and difficult circumstances.

This recommendation has been accepted by the Prison Service.