PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Whatton in March 2013

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 at HMP Whatton in March 2013. He died from stomach cancer. He was 72 years old. I offer my condolences to those who knew him.

A clinical reviewer of the medical care the man received at Whatton was carried out. HMP Whatton co-operated fully with the investigation.

The man had been in prison for over six years and took medication for high blood pressure and cholesterol. In November 2012 he was diagnosed with stomach cancer, for which only palliative treatment was possible.

I am satisfied that the man received a very good standard of care at Whatton which was at least comparable to that he could have expected to receive in the community. He was particularly well supported at the end of his life for which the prison deserves commendation. However, as I have found in some previous investigations at Whatton, restraints were sometimes used inconsistently and inappropriately when he was taken to hospital.

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 **December 2013**

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SUMMARY

1. The man had been in prison since 2006. In August 2012, he complained of pain in his left side that had lasted several weeks. In early September, blood tests were requested and, although the results came back abnormal, it was 12 days before a GP saw him. The GP referred him urgently to hospital with suspected cancer. Further tests showed that he had stomach cancer. The slight delay in the GP seeing the results of the blood test did not affect the outcome for him, but we consider improvements could be made in the way in which test results are brought to the attention of GPs.

2. The GP and lead palliative care nurse at Whatton spoke to the man on 1 November to tell him about the cancer diagnosis and discuss his treatment options

3. After the man's diagnosis, Whatton provided good, supportive care. He spent much of November 2012 in hospital having blood transfusions and surgery to remove part of his stomach. Restraints were removed while he was in hospital, but decisions about risk were inconsistent. For several subsequent outpatient appointments, he was restrained using an escort chain and escorted by two members of staff even though his mobility was poor and he was very ill. Some of the risk assessments did not include sufficient information from healthcare staff about how his medical condition impacted on the likelihood of escape.

4. After his diagnosis, the man spent most of his time in a specially adapted cell on A wing at Whatton. After a short hospital stay in March 2013, when it was evident that he was at the end of his life, he moved to The Retreat, the palliative care facility at the prison. He died there at the end of March. From December 2012, a prison family liaison officer had made commendably extensive attempts to track down the man's brother in Canada, but was unsuccessful. He had no other family.

5. We make two recommendations about following medical tests results and the use of restraints.

THE INVESTIGATION PROCESS

6. Notices were issued at Whatton announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.

7. The investigator visited Whatton on 5 April. She collected documents relating to the man's time in custody and visited the areas of the prison where he lived. She returned to Whatton on 7 May 2013 and interviewed three members of staff and one prisoner.

8. The local Primary Care Trust (PCT) asked a clinical reviewer to assess the man's clinical care at the prison. He was given all the relevant documents to assist his review.

9. A copy of the investigation report has been sent to the local Coroner.

10. The prison was unable to trace any next of kin so we have not been able to inform the man's family of the investigation.

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

HMP WHATTON

12. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 prisoners. All the prisoners are sex offenders.

13. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Healthcare Foundation Trust. The healthcare centre is open daily from 8.00am to 7.30pm, with a local out of hours service providing cover at night and at weekends. Specialist clinics are provided for older prisoners and those with life long conditions. There are no inpatient beds at Whatton. Prisoners with terminal illnesses are able to spend their last days in a purpose built palliative care suite known as the Retreat, which was funded by the King's Fund.

HM Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) last inspected Whatton in January and February 2012. The prison was found to be safe and decent. Health services were judged to be generally good with staff who were polite and responsive to prisoners' needs. Primary care was well organised and access to nurse-led, GP and dental services was good. There was a wide range of chronic disease clinics and enablement therapies to meet the needs of the population. Medication administration was found to be compromised by the lack of appropriate supervision of some medication. Palliative care arrangements were described as particularly good.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to May 2012, the IMB reported favourably on healthcare services. They were satisfied that the clinical needs of all the prisoners were met and noted there was a high quality of care for prisoners with terminal illness in the palliative care suite in the healthcare unit.

Previous deaths at Whatton

16. We have investigated a number of natural cause deaths at Whatton. Many of the other prisoners had long-term medical conditions. Some of the other recent investigations at Whatton found there were occasions when the use of restraints for hospital appointments was inappropriate.

ISSUES

The diagnosis of the man's terminal illness

17. The man had been sentenced to prison in 2006 and transferred to Whatton in 2008. During 2012, he had been prescribed atenolol for hypertension (high blood pressure), simvastatin to control elevated cholesterol and diclofenac sodium to reduce inflammation and paracetamol. His blood pressure was checked at regular intervals and it was usually within the normal range. A nurse saw him on 23 August 2012, when he said he had suffered from a pain in his left side for about six weeks, which was worse in the morning and eased when he walked. He said he was not in pain anywhere else and described it as a dull ache rather than a stabbing pain. He also complained of black stools but said that, since he had stopped taking diclofenac, these had gone. The nurse carried out an ECG test and referred him to see a GP.

18. A doctor saw the man on 4 September and noted he had a history of left upper quadrant pain in his stomach and had had two episodes of diarrhoea in the previous ten days. The doctor ordered some tests (ultrasound, full blood count and blood haematinic levels) and noted that he might have viral gastroenteritis. The blood count results arrived on 14 September, and showed iron deficiency anaemia with a haemoglobin level of only 8.5g/dL. (The normal range is 13-18.)

19. A nurse saw the man on 19 September and thought wind and colic pains might be caused by gastroenteritis. She asked a GP to prescribe a drug to relax the muscles around the gut. The haematinic blood test came back as abnormal on 21 September.

20. On 26 September, a doctor saw the man and noted the results of the blood tests. He recorded that he had taken diclofenac for seven months but had stopped two weeks earlier (which was a possible cause of his anaemia) and that he still had some upper abdominal discomfort. He decided to refer him urgently under the fast track referral system for suspected upper gastrointestinal cancer. He also started him on a course of iron supplements and acid suppression therapy.

21. The man had an ultrasound scan of his abdomen at hospital on 8 October, from the referral on 4 September. The scan found there was a cystic structure in the neck of his pancreas and that he had "fatty liver disease" (where large vacuoles of fat accumulate in the liver cells). A prison GP reviewed the results and referred him to surgeons for further evaluation.

22. On 19 October, the man had an upper gastrointestinal endoscopy at hospital. The results showed that he had a cancerous gastric ulcer (stomach cancer). On 31 October, a further endoscopy was cancelled because histology results had confirmed stomach cancer and CT scans were now required.

23. The clinical reviewer considered that the diagnosis was appropriate and timely. He commented that the only delay was between the results of the

blood count being noted on SystmOne on 14 September, and when the man saw the GP on 26 September. Although the clinical reviewer said it would not have made a difference to the outcome for him, he considered that it highlighted a potential problem if test results were not seen and acted on as soon as they became available. We make the following recommendation:

The Head of Healthcare should ensure that test results are given to GPs as soon as possible so that any necessary action can be taken promptly.

Informing the man about his condition and treatment

24. A prison GP met the man on 1 November, the day after the results of tests had confirmed stomach cancer. She told him that he would have a CT scan and possibly surgery if the cancer had not spread. She noted that he was in significant pain and not eating. A palliative care specialist spoke to him about his diagnosis that afternoon and on 5 November, gave him a booklet "Understanding stomach cancer".

25. After his surgery the possibility of palliative chemotherapy was discussed with the man, but he later decided not to pursue chemotherapy.

26. We are satisfied that the man was told about his illness and treatment options in a considerate and timely manner. The palliative care specialist saw him frequently and gave him appropriate support and information.

The man's medical appointments and treatment

27. The man was given his diagnosis on 1 November. A full blood count was carried out the next day and he was admitted to hospital that night. He was discharged the following day after receiving three transfusions to help his haemoglobin levels. He was readmitted to hospital on 8 November for more blood transfusions.

28. The palliative care specialist maintained contact with the hospital and the Head of Residence went to see the man on 13 November. His haemoglobin levels were still low, despite six blood transfusions in the previous five days. The palliative care specialist wrote that the CT scan had showed lesions on his liver where the cancer had metastasised.

29. The man had a partial gastrectomy (a surgical removal of part of the stomach) at the hospital. On 26 November, he returned to Whatton with enoxaparin injections (used to prevent and treat deep vein thrombosis or pulmonary embolism). He was also given cyclizine, lansoprazole metoclopramide and senna (all for gastric symptoms) and tramadol (to treat moderate levels of pain).

30. The man discussed chemotherapy with an oncologist at the hospital on 18 December and had further appointments about this on 31 December and on 8 January 2013. Before he could go ahead with the treatment, further tests and a CT scan were needed.

31. On 5 February, the man went to hospital and saw a doctor, who noted that he had not attended hospital for his CT scan the day before. (The prison had not received an appointment letter and was not aware of the scan, which was rebooked for 7 March.) A hospital doctor planned for him to have 12 weeks of chemotherapy and then a CT scan to monitor progress. The man said he would make a final decision about chemotherapy after the initial CT scan which was completed on 7 March.

32. The man felt too unwell to attend a hospital appointment on 14 March. When a doctor saw him the next day, they discussed chemotherapy and agreed that he was now too weak for it.

33. On 25 March, the palliative care specialist saw the man, who said he did not feel well enough to attend an oncology appointment later that week. He went to hospital that afternoon for a stent to be inserted to move an obstruction in his bile duct which was causing jaundice, nausea and itching. However, he was too unwell for the procedure. He returned to Whatton on 26 March where he was admitted to The Retreat for end of life care.

34. We are satisfied that the prison ensured that the man was able to attend hospital appointments for consultations, treatment and scans as required. One CT scan on 4 February was cancelled as the prison was not aware of the appointment. The clinical reviewer was satisfied that this did not affect the outcome.

The man's pain relief and medication

35. On 18 February, the man told the palliative care specialist that he was finding it difficult to "get on top of pain". A doctor saw him within an hour and changed his medication to zomorph (a morphine-based, slow release pain killer used to treat severe pain) and sevredol (another morphine based pain killer to help treat any sudden onset of pain). When the palliative care specialist saw him a few days later on 22 February, she noted that his pain was not under control and that he was not taking the sevredol. She reminded him to take it. She said he was much brighter the next day and his pain control level improved.

36. On 25 February, a doctor wrote that the man had been struggling with his pain and was worried about "over-treating" himself. She doubled his zomorph level and planned a review in a week. She noted his appetite was poor and prescribed Fortisip drinks.

37. From March, nurses started to take the man's medication to him in his cell as he was too unwell to go to the healthcare unit to collect it. A doctor saw him on 4 March, as he was not taking his medication in sufficient quantities to control his pain. She changed morphine to oxycontin and oxynorm. This seemed to help and on 7 March he told staff that the pain was better and he had started to eat.

38. A doctor increased his pain relief medication on 11 March. She felt that he did not always remember to take it and decided to set up a system of reminders, using the on-call nurse in the prison. On 14 March, the palliative care specialist considered his pain was well controlled with the increased dose.

39. On 18 March, a doctor saw the man again and observed an obvious deterioration. She noted that once he was not mobile, he should move to The Retreat. She organised medication in anticipation of him going there, including arranging a syringe driver.

40. We are satisfied that the man's pain relief was appropriately managed. He was prescribed pain relief, which was reviewed and changed when it appeared not to be effective in controlling his background and breakthrough levels of pain. The clinical reviewer noted that healthcare staff made regular checks to ensure he had taken his medication as prescribed.

Liaison with the man's family

41. The man's pre-sentence report in 2006 noted that he had no family apart from a brother who had moved to Canada. At the time the pre-sentence report was written, they had not been in contact for over two years and he had had no further contact with his brother while he had been in prison.

42. The man was appointed a family liaison officer (FLO) in December 2012. He noted that, although his brother was listed as his next of kin on his prison records, there were no contact details. The FLO used social media sites to try and track down the brother, using his name and last known approximate location in Canada. He sent emails to a possible match but did not receive a reply. He told the man this in early February.

43. On 4 March, the man told staff that one of his concerns was not being able to contact his brother. They suggested he write a letter that his solicitor could keep, so that if his brother could be traced in the future, it could be given to him. He was offered help to write the letter, but his condition deteriorated before he was able to do so.

44. On 24 March, the FLO told the man that he had asked the Canadian High Commission for help but was still waiting for a reply. He told the FLO not to worry about this. As the prison had not been able to trace his brother by the time of his death, they arranged his funeral, which took place on 22 April 2013. The prison chaplain took the service.

45. We are satisfied that Whatton took all reasonable steps to try and find the man's brother and began their efforts to do so soon after his diagnosis.

The man's location

46. After his diagnosis and initial hospital treatment, the man returned to C1 unit at Whatton on 26 November, where he had been living until then. The next day he moved to a special cell on A8 wing which is larger than normal and

has a hospital bed and a shower en suite. He was assisted by Disability Awareness Co-ordinators on the wing. (DACs,are prisoners who help with some daily living needs such as collecting meals and cleaning cells.) A friend from C1 was able to visit him regularly.

47. On 1 February, the man told the palliative care specialist in discussion that he would prefer to end his life at Whatton, if early release was not an option. He remained in the cell on A8 until 25 March when he went to hospital. He chose to return to Whatton the next day and was admitted directly to The Retreat, where he spent his last days until he died.

48. We are satisfied that the man was accommodated according to his wishes and with appropriate facilities to meet his needs.

Compassionate release

49. Early release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be released from custody before their sentence has expired. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds is granted by the Secretary of State only in exceptional circumstances.

50. The man told the palliative care specialist on 1 February that he had spoken to his solicitor about applying for compassionate release but no formal application was received. While it would have been good practice to have recorded that the possibility of compassionate release had been considered we accept that it is highly unlikely that he would have met the criteria. He had no family to look after him and there would have been no significant benefit for him, who would have needed supportive care in a hospital or hospice.

Palliative care plans

51. On 1 February 2013, the palliative care specialist initiated the Gold Standard Framework for cancer care (a systematic approach to optimising the care for patients nearing the end of their life) for the man. She noted that he was independent (although helped by the disability coordinators on the wing) and his appetite continued to improve.

52. She continued to see the man regularly to support him. She monitored his pain levels and made appointments for him to have his medication reviewed by the GP as and when required. She checked that he could perform daily living tasks such as getting washed and dressed.

53. On 15 March, the man discussed resuscitation with a doctor. He agreed that he did not now want to be resuscitated in the event of a cardiac or respiratory arrest.

54. The man returned to Whatton from hospital on 26 March in accordance with his wish to die in the prison and was admitted straight to The Retreat, where 24 hour one to one care was provided. The Liverpool Care Pathway for the dying had been started at the hospital and continued at Whatton. A syringe driver to administer pain relief automatically was set up.

55. On 27 March, the palliative care specialist helped the man during the day and a doctor tried to talk with him. He slept on and off during the day and nurses reported that he was comfortable. He was now on stage 3 of the Gold Standards Framework, with a prognosis of a few days. Some prison friends visited him the next day, but he became unsettled overnight. On the day of his death he appeared more comfortable but slept most of the day. He was given diamorphine, levomepromazine and midazolam (medicines that are commonly used in palliative care and in the last few days of life). He died at 6.50pm that evening.

56. The man's medical records show that the Gold Standards framework and Liverpool Care Pathway was started at the appropriate time. We are satisfied that timely palliative care was put in place and staff were responsive to his needs in accordance with the agreed care plan.

Restraints, security and bed watch

57. 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.

58. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

59. The man was admitted to hospital on 8 November 2012 and stayed there until he was transferred to another hospital for surgery on 16 November. His risk assessment indicated he was considered a low risk of escape and low risk of harm to the public. Despite this, the authorising manager decided that he should be restrained using an escort chain and accompanied by two officers. Daily management visits were carried out and his risk was reassessed at each of these visits. On 9 November, he completed the check. He noted that his mobility level was low and that he used a wheelchair, his behaviour was

excellent and there was no intelligence to suggest he was planning to escape. He decided that the level of escort should remain at two officers and he should continue to be restrained by an escort chain. Management checks on 10, 11 and 12 November maintained the same arrangements.

60. On 13 November, the Head of Residence visited the man and decided to remove the restraints and reduce the number of officers on the escort from two to one, because of the seriousness of his condition, his limited mobility and the fact that he had no relatives or friends in the community. (This meant he would have had little motivation to escape as he had nowhere to go and no one to look after him.) She wrote "All risks assessed as low… very good behaviour. If staff have any concerns about security or vastly improved condition – contact the duty governor for advice". We are pleased to see that she revised the original risk assessment after visiting him. For the rest of his stay in hospital, until 26 November, he remained unrestrained and with one officer escort. There were no concerns about his behaviour or risk.

61. The risk assessment for the man's next outpatient appointment on 18 December indicated that he would be going in a wheelchair. (He could move around the wing and his cell but needed a wheelchair for longer distances). He was considered to be a low risk to the public, of escape, of having assistance to escape and to hospital staff. The palliative care specialist completed the 'medical information' section of the form and ticked that there was no medical objection to the use of restraints but did not give any further information about his medical condition. An operational manager decided that he should be accompanied by two officers and restrained using an escort chain. The same decisions were reached for appointments on 31 December, 8 January 2013 and on 5 February, although he was still assessed as low risk.

62. When the man went to hospital on 7 March for a CT scan, much of the risk assessment was the same as previously, but this time a nurse indicated there were medical objections to the use of restraints and wrote that he was a palliative care patient. The operational manager decided to send him out with two officers but no restraints. He commented "Only apply restraints if mobility is good and staff feel there is imminent risk of escape".

63. The final time the man was taken to hospital was on 25 March. He stayed overnight before returning to The Retreat. The escort risk assessment noted his use of a wheelchair and that he was considered a low risk of escape, to the public and to hospital staff. A nurse ticked that there were no medical objections to the use of restraints and did not give any other information that might influence the escort, although he was very unwell at the time and close to death. The authorising manager decided that no restraints were necessary and noted that he was a seriously ill man with a low escape risk.

64. We accept that the risk of escape and to the public in general can be higher for an outpatient appointment than for a hospital stay, but it is difficult to see in this case how the discrepancy in decisions about the use of restraints could be justified. Most of the risk assessments did not contain information about how his medical condition impacted on his risk as the court judgement and

subsequent Prison Service guidance require. We would have expected each of the healthcare sections at least to have indicated that he was terminally ill and had poor mobility. There is no section on the escort risk assessment form to note previous decisions which would help avoid discrepancy in decisions. The fact that he had stayed in hospital with only one officer escort and no restraints for 13 days in November should have been considered.

65. We have made a number of previous recommendations to Whatton about the use of restraints and consider there is a need for all those involved in making decisions, including healthcare staff, to familiarise themselves with the principles of the High Court judgement which were circulated to all prisons after the case and reiterated last year as a result of concerns from this office. We make the following recommendation.

The Governor should ensure that the use of restraints for hospital escorts reflects the prisoner's actual risk at the time, and that information from healthcare and from previous escorts should help inform this decision.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that test results are given to GPs as soon as possible so that any necessary action can be taken promptly.

2. The Governor should ensure that the use of restraints for hospital escorts reflects the prisoner's actual risk at the time, and that information from healthcare and from previous escorts should be made available to help inform this decision.

ACTION PLAN: The Man – HMP Whatton

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that test results are given to GPs as soon as possible so that any necessary action can be taken promptly.	Accepted	Whatton has since reviewed its procedures relating to prompt action of test results. New procedures have now been put in place – which are: On receipt of any results the document is scanned into the patient record on system one and flagged for the attention of the GP. A paper copy is placed in the GP file to be actioned by the GP of the day. This is recorded into the patient record on system one as are any follow up comments.	Completed Head of Healthcare to monitor the effectiveness.	
2	The Governor should ensure that the use of restraints for hospital escorts reflects the prisoner's actual risk at the time, and that information from healthcare and from previous escorts should be made available to help inform this decision.	Accepted	A system has been put in place whereby a risk assessment is undertaken prior to each hospital escort that takes full account of the prisoner's current risk and which considers information from healthcare and previous escorts of the same prisoner. Staff have been reminded that the risk assessments need to record all information that was taken into consideration when making the decision and monitoring is now in place to ensure that this requirement is met.	Completed Head of Healthcare to ensure all Healthcare staff understand the importance of correct documentation of risk assessments.	