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 hospital in September 2012 while in the custody of HMP Woodhill

Our Vision

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

This is a report into the death of a man while in the custody of HMP Woodhill. He died from cancer at hospital in September 2012. He was 66 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer conducted a review of the man's clinical care at Woodhill.

The man had an operation to remove a tumour from his colon in July 2010, before he was remanded to custody in October 2010. In December, he was told the cancer had spread to his lungs and he started chemotherapy shortly afterwards. He was sentenced to 15 years imprisonment in June 2011. In December, he was told that the cancer had spread further and palliative chemotherapy was started, but stopped in May 2012 because of the side effects. His health deteriorated over the next few months and he was admitted to hospital, where he died the next day.

The clinical reviewer found that Woodhill lacked appropriate palliative care arrangements. In consequence, healthcare staff did not effectively monitor or communicate with the man during the last weeks of his life, and responded too slowly to his rapid deterioration. The investigation also identified other areas for improvement: compassionate release was not considered, the level of restraints used on escorts to hospital was not always justified by the risk assessment and family liaison arrangements were poor. Overall, while efforts were made to meet his wishes in respect of his location in the prison, I do not consider that end of life care for him was delivered to a good standard.

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 **August 2013**

CONTENTS

Summary

The investigation process

HMP Woodhill

Issues

Recommendations

SUMMARY

1. The man was born in March 1946. On 29 October 2010, he was remanded to HMP Woodhill charged with sexual offences against children. He was sentenced to 15 years on 24 June 2011.

2. At his initial health screen, the man reported that he had had a heart bypass operation in July 2010 and that he had been diagnosed with a rectal tumour while recovering from the bypass. His heart condition was monitored and his tumour was being treated at hospital.

3. On 7 December 2010, the man's oncologist told him that the cancer had spread to his lungs and he had between 18 months to two years life expectancy if he responded to chemotherapy. He was admitted to the prison's healthcare centre on a number of occasions but he preferred to stay on the wing, so his cell was adapted in June 2011 to allow him to stay there.

4. In November 2011, the man was told by the hospital's oncology team that despite chemotherapy the cancer was spreading and his treatment would be changed to palliative chemotherapy to alleviate his symptoms. In May 2012, the chemotherapy was stopped because of the side effects he was experiencing, but there is no record that this was discussed with him or that he was offered support.

5. Officers noticed that the man was particularly unwell at the end of July. A prison doctor saw him on 10 August and recorded that he had a very poor appetite. He told a healthcare assistant two days later that he felt unwell but, other than to administer medication, there are no records of him being seen by anyone from the healthcare team for the next 18 days. On Friday 31 August, his condition started to deteriorate overnight. He was taken to hospital in and died the following morning.

6. The investigation found that healthcare staff did not effectively monitor the man's condition in the last weeks of his life, and responded too slowly to his rapid deterioration at the end of August. There was a lack of palliative care resources to manage and monitor those at the end of their lives. We repeat a previous recommendation about the need to keep prisoners with terminal illnesses informed of their condition and treatment. We are concerned that hospital appointments were cancelled for unsubstantiated security reasons and that the level of restraints used when taking him to hospital was not justified by the risk assessment. The prison did not consider his suitability for compassionate release.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 3 September 2012. The investigator issued notices informing staff and prisoners of the investigation and asking them to contact her with any relevant information. She spoke to one prisoner as a result.

8. The investigator obtained copies of the man's medical record and relevant prison records. The local PCT appointed a clinical reviewer to conduct a review of the clinical care he received at Woodhill. The clinical reviewer was given a copy of his medical record.

9. The investigator visited Woodhill in October and November to conduct interviews with prison staff. The clinical reviewer joined her for clinical interviews.

10. The investigator informed HM Coroner for Buckinghamshire of the investigation. A copy of the report will be sent to the Coroner to assist his enquiries.

11. One of the Ombudsman's family liaison officers contacted the man's brother to outline the purpose of the investigation and to ask him if there were any issues he wished the investigation to consider. He had no questions about his brother's treatment.

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

13. A copy of the draft report was sent to National Offender Management Service (NOMS). They reported that there were no factual errors and accepted all the recommendations. The responses to the recommendations are repeated verbatim in the relevant section.

14. The man's family received a copy of the draft report as part of the consultation period. Having considered the investigation findings, his family have indicated the concerns noted in the report. They welcomed the recommendations made, making reference in particular to the ones concerning the use of restraints, the keeping of appointments and family contact.

HMP WOODHILL

15. HMP Woodhill has the dual role of a local prison and a high security prison and holds up to 819 prisoners. It takes adult male prisoners and young offenders from the Magistrates and Crown courts in the Milton Keynes area and also holds category A prisoners (prisoners regarded as of high risk to the public should they escape). It has a Close Supervision Centre housing prisoners whose behaviour is especially complex or challenging. There is also a unit for protected witnesses.

16. The local PCT commissions health services at HMP Woodhill. A private healthcare company provides general medical services. The prison has a nursing health care team, a mental health in-reach team, and X-ray, dental, pharmacy and podiatry services.

Her Majesty's Inspectorate of Prisons (HMIP)

17. The most recent inspection of HMP Woodhill was an unannounced inspection in January 2012. The Inspectorate found that, because of high levels of staff vacancies and sickness, the range of health services did not meet the needs of the population Required nurse-led clinics were not delivered and prisoners had a negative perception about the quality of health services. Links had been made with local palliative care services, but they had not yet been developed.

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained.

19. In its most recent annual report (2011-12), the IMB was very concerned about the longstanding shortfall in healthcare staff, which meant that the range of healthcare services did not meet the needs of prisoners. The board said that the needs of older prisoners were well met and the inpatients' unit was described as calm, bright and spacious. The IMB did not comment on palliative care services.

Previous deaths at HMP Woodhill

20. The Ombudsman has investigated five previous deaths at Woodhill in the last two years, two of which were due to natural causes. After a death in December 2010, we recommended that prisoners with a terminal illness should be kept informed about their treatment, and that the use of restraints should be proportionate to a prisoner's risk. We revisit both of these issues in this report.

ISSUES

The diagnosis of the man's terminal illness

21. When he arrived at HMP Woodhill on 29 October 2010, the man told the doctor that he had had a heart bypass in July 2010. He had already been diagnosed with cancer and had had an operation for a tumour in his colon in July 2010 and had a colostomy. His heart condition was being monitored by the cardiology department at hospital and he had an outstanding oncology appointment at the same hospital. He said that he was partially deaf, had gout, hypertension, a collapsed lung and that he had suffered a stroke in December 2009.

22. The man attended his oncology appointment at hospital on 7 December 2010. He was told that his cancer had spread to the lungs and his prognosis was 18 months to two years if he responded well to chemotherapy.

Informing the man about his condition and treatment

23. When he returned to the prison on 7 December, the man informed the reception nurse that he had been told that the cancer had spread to his lungs. The information was passed to managers and healthcare staff. A doctor spoke to him and they discussed his chemotherapy treatment and the support that he had from his brother. The doctor recorded that he was devastated by the news, but not suicidal or severely depressed. He declined the doctor's suggestion of sleeping tablets. The doctor asked officers on the wing to keep an eye on him.

24. In November 2011, the man was told by the oncologist at hospital that his cancer had continued to spread, and his chemotherapy treatment was adjusted. In May 2012, the hospital wrote to the prison to explain that the chemotherapy was only reducing some of the cancer, but was causing significant numbness in his hands. Because of this side effect, the consultant withdrew chemotherapy treatment and decided that his condition would be monitored, starting with a computerised tomography (CT) scan. (A CT scan is a specialised X-ray used to build detailed pictures of the inside of the body.) There is no record that he had a CT scan before he died.

25. There is no evidence that any healthcare staff at the prison discussed the content of this letter with the man. On 20 June, a specialist palliative care nurse from the community visited him. It is not clear from the record of the meeting, whether he discussed the withdrawal of chemotherapy with the nurse.

26. The clinical reviewer reports that the hospital discussed the deterioration of his health with him in May 2012, but there is no note of this discussion or follow-up support from prison healthcare staff. Using palliative care nurses to discuss treatment with prisoners with terminal illness does not discharge the prison's own responsibility to keep prisoners informed about their condition and treatment.

27. The man was appropriately supported in December 2010 when it was first discovered that his cancer had spread, but there is no evidence that healthcare staff spoke to him when chemotherapy treatment was withdrawn in May 2012. In a previous investigation of a death in December 2010, we found that there was no record that prison staff spoke to the prisoner about his terminal

condition or treatment. The Governor accepted a recommendation to ensure that staff keep seriously or terminally ill prisoners informed about their condition and treatment, but this does not appear to have been followed in his case. We repeat the recommendation:

The Governor and the Head of Healthcare should ensure that seriously and terminally ill patients are informed about their condition and treatment and record these discussions.

The man's medical appointments and treatment

28. When the man was remanded to Woodhill on 29 October 2010, he had an outstanding oncology appointment at hospital on 2 November, which he did not attend. He also had an appointment with the rheumatology department in January 2011, which was cancelled twice. Healthcare staff recorded that the appointments were cancelled because he knew when they were scheduled, and therefore there was a risk of planned escape.

29. Woodhill's Deputy Governor explained that the prison might change a prisoner's hospital appointment if the man was aware of the time and date, to preclude any assisted escape attempts. She said that she would expect to see the reason for the cancellation of the appointment in the medical record or security file. He was considered a low risk of escape and there were no markers in his security file to indicate an increased risk of escape at the time of these appointments. There is no evidence that the healthcare department contacted the security department to establish his level of risk.

30. The Prison Service national Security Policy Unit told the investigator that the National Security Framework, which governs prisons' local security arrangements, is not specific about the cancellation of hospital appointments when a prisoner knows the time and date. It does not require that they should be cancelled automatically and it is expected that a prisoner's condition and the urgency of the treatment should be taken into account when the prison decides whether to cancel an appointment.

31. We are concerned that the man's access to necessary medical treatment was affected by the cancellation of appointments without proper consideration of whether the cancellation was necessary.

The Governor and the Head of Healthcare should ensure that prisoners' hospital appointments are not cancelled unless there are properly justified and recorded reasons.

32. The man first attended a hospital appointment on 7 December 2010 when he was told his cancer had spread. He received regular chemotherapy from January 2011. He attended hospital at least 37 times between January 2011 and August 2012. Although these appointments are recorded on the prisoner movement database, few are mentioned in his clinical record. The Primary Care Lead told the investigator that she would not necessarily expect to see an entry to correspond with every hospital appointment. We consider that in order to ensure effective continuity of care between the hospital and the prison, healthcare staff should have had a recorded discussion with him each time he returned to prison from a hospital appointment to assess his needs.

The Head of Healthcare should ensure that prisoners returning from hospital appointments have a recorded assessment by healthcare staff.

Palliative Care

33. In November 2011, the man was told that the cancer was spreading and palliative chemotherapy was started in December. After this, he was supported by a prisoner carer on the wing. The prisoner was paid to help with some of his social care needs such as disposing of his colostomy bag and collecting his food.

34. In February 2012, a MacMillan nurse saw the man at Woodhill and suggested that he increased his paracetamol, but otherwise recorded that she was happy with his care. She did not schedule another visit, but invited him to call for advice or if he wanted to see her again. On 20 June 2012 a palliative care nurse from a local hospice saw him after his chemotherapy treatment was stopped. The nurse reviewed his care plan and said he was pleased with his progress. He did not suggest any change to the care plan and did not arrange another appointment.

35. On 24 July, the officer reported to healthcare staff that the man was having trouble eating and drinking and that she was concerned about him. Although nurses dispensed medication to him three times a day, it is a concern that despite his terminal condition, he was not seen by a doctor until 10 August. The doctor recorded that he had felt unwell for a few days and was more tired than usual. His blood pressure and pulse were normal. The next day, a nurse saw him and recorded he was unwell and pale. There are no entries in his medical records to indicate that this was followed up in the next 18 days.

36. The man's condition began to deteriorate significantly from Friday 31 August. He was seen by a doctor on the afternoon of 1 September. He was concerned he had had a stroke but the doctor found no evidence of this and concluded that he was pale and tired. The doctor recorded that his blood pressure, temperature and pulse were all normal. He described him as a "palliative care patient with stable observations". The doctor told the nurse on duty that he was okay and just to keep an eye on him.

37. An officer was on duty of the night of 1 September and was told that the man had been reviewed by the doctor during the day but remained on the wing. She recorded in the observation book and his wing history sheet that she was worried that his health was deteriorating. She checked him every half an hour through the night and suggested that he drink water on a couple of occasions to keep hydrated. A nurse said she checked him twice during the night through his cell door observation panel.

38. The officer called the nurse at 7.42am because she was worried that the man had not slept and was hallucinating. The nurse passed the concerns to another nurse, who was starting her shift. A doctor, accompanied by the oncoming nurse, assessed him again that lunchtime, when he was very breathless and his saturations had dropped to 84 per cent from 94 per cent the day before. (Saturations are the amount of oxygen flowing through the lungs.) The doctor

concluded that he needed to go to hospital and the nurse requested a non-emergency ambulance, which arrived very quickly at 1.15pm.

39. The clinical reviewer is concerned that the first nurse observed the man only through the observation panel on his door overnight on 1/2 September and did not properly assess him, despite the officer's concerns and his terminal condition. Once the doctor assessed him properly on 2 September, the extent of his deterioration was clear and he was taken to hospital.

40. We share the clinical reviewer's concern that the involvement of specialist palliative care services was not structured but managed on an ad hoc basis. We are also concerned that the man's condition was not proactively monitored and healthcare staff failed to respond when officers raised concern. The clinical reviewer concludes there is a lack of structure for managing prisoners on a palliative care pathway at Woodhill. He writes:

    ”There is no clear pathway developed and defined;
    There is no clinical lead;
    There is no multidisciplinary review of patients in this category;
    There is no structured training in this area;
    There is no structured involvement of relevant outside specialist agencies such as the hospice or Macmillan Service
    There is a lack of knowledge and experience in managing patients in the terminal phase of Palliative Care
    The involvement of outside agencies is not continued into the terminal phase.”

41. The clinical reviewer makes several recommendations about the delivery of palliative care to prisoners at the end of their lives. We have reframed these recommendations as follows:

    The Governor and Head of Healthcare should implement a palliative care pathway to ensure a multidisciplinary approach for managing prisoners at the end of their lives and that full healthcare assessments take place as necessary for such prisoners, regardless of the time of day.

The man's pain relief and medication

42. The clinical reviewer is satisfied that the man's cancer treatment was managed appropriately until his condition started to deteriorate from July 2012.

43. The man's chemotherapy was withdrawn on 20 June. Officers reported that they were concerned that he was not eating or drinking on 24 July. Nurses dispensed medication to him three times a day, but recorded no observations. A doctor saw him on 10 August, more than two weeks after officers had raised concerns. By 31 August, he complained that he was hallucinating, and in pain.

44. Healthcare staff should have been quicker to respond to officers' concerns. The clinical reviewer is concerned that the lack of staff training and experience in palliative care might have contributed to the failure to adjust the man's medication to manage his pain and hallucinations. We agree that the lack of a structured approach to his palliative care meant his medication and pain relief was not effectively managed by the healthcare team.

The Head of Healthcare should ensure that there is a proactive approach to pain management for prisoners with a terminal illness.

The man's location at Woodhill

45. During the man's illness he wanted to remain on the wing rather than be in the healthcare centre. He said he was bored in the healthcare centre, which caused him to feel low and asked to return to the wing to be with his friends. Once he was discharged from hospital, he refused to stay in the healthcare centre and returned to his own cell. A buddy was appointed to facilitate his care on the wing.

46. The man's cell was one of three on the ground floor. The cell had been adapted to meet his needs and he had a cell bell positioned by his bed to call for help if necessary. He had a pressure relieving mattress on a hospital bed, to prevent bed sores.

47. It is appropriate that terminally ill patients should be involved in decisions about their location. We are satisfied that the man was consulted, and his wishes respected, about his location in the prison, and that the prison provided suitable facilities for this.

Restraints, security and bed watch

48. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

49. The investigator reviewed the restraint risk assessment documents for the man's hospital visits. His risk of escape was assessed as low throughout his time at Woodhill, as was his risk of hostage taking. His risk to the public was always considered to be medium, and sometimes it was noted that this was particularly in relation to his risk to children. Apart from the nature of his offence (historic sex offences), there was no security information to indicate that he was a risk to the public, escape or hostage taking. Despite being assessed as low risk of escape he was double-cuffed and two officers escorted him to hospital. (Double cuffs means that two pairs of handcuffs are used; one to cuff the prisoner's wrists together in front of him and one to cuff one of his wrists to that of an officer.)

50. When the man was taken to hospital in September, he was again double cuffed. After 90 minutes at the hospital, officers were advised that he would remain in hospital for several days, so the cuffs were removed, and he was restrained by an escort chain. He stayed in hospital overnight. The next morning, officers were told that he did not have long to live. The escort chain was removed at 10.32am and he was pronounced dead eight minutes later, at 10.40am.

51. A nurse completed the medical sections of the escort risk assessment and indicated that there were no medical objections to restraints and the man's condition was not life-threatening. She left blank the sections asking whether there were any procedures which required restraints to be removed and whether there were any other medical conditions that were likely to influence the escort. She told the investigator that she does not normally complete those sections, because she does not know what treatment a prisoner will receive while they are on escort. The Primary Care Lead explained her view that it is very difficult for medical staff to rule out the possibility of escape. However, there was no medical assessment about how his state of health might impact on his risk of escape as court judgement requires.

52. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. The man had been diagnosed with a terminal illness and assessed as a low risk of escape and a medium risk to the public should he do so. When he was taken to hospital in September he was very seriously ill, yet was still double cuffed. Restraints were not fully removed until minutes before his death. His physical health was not taken into account sufficiently in the escort risk assessments which did not justify the level of restraints used.

    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.

Liaison with the man's family

53. The man was in contact with his brother throughout his time in prison, and his brother visited him often. In February 2011, there was an entry in his medical records suggesting officers should "arrange for the appointment of a FLO [family liaison officer] through safer custody". There is no evidence that this was done at any point while he was at Woodhill.

54. At 25 minutes past midnight on 3 September, the hospital doctor requested next of kin details from the prison officers who were escorting the man. The officers rang the night duty manager, who then asked a nurse to ring the hospital and ask whether they could wait until the morning. The nurse did as she was asked, and the hospital agreed that the details could wait. At 9.00am, the hospital contacted the prison for his family contact details again, but were told that there were no contacts in his records.

55. A prison FLO was appointed and started a log at 9.30am on 3 September. By this time the man's brother's details had been found. After the man died, the FLO went to his brother's home to break the news, but there was no one in. He left two telephone messages over the next five hours asking his brother to call the prison, but there was no response.

56. By this time, the news of the man's death had reached his family through other prisoners. The man's brother was abroad and returned to the UK the next day. The FLO spoke to him at 5.00pm on 4 September, and arranged for him to visit Woodhill the next day to collect his brother's property and visit the cell. The prison paid the funeral expenses in full.

57. Prison Service Instruction (PSI) 64/2011 Safer Custody, requires:

> "*Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill.*"

58. If the prison had appointed a family liaison officer as first suggested in February 2011, the confusion about family contact details on 3 September, when he became critically ill, might have been avoided and it should have been possible to inform the man's brother about the change in his condition before his death. Prison Rule 22 requires governors to inform the next of kin if a prisoner becomes seriously ill. We consider it best practice to ensure that a properly trained family liaison officer, who can act as a consistent and central point of contact for the family, is appointed at the earliest appropriate time when a prisoner is diagnosed as terminally ill so that they can be kept informed of any deterioration in the prisoner's condition.

The Governor should ensure that a family liaison officer is appointed when a prisoner is seriously or terminally ill.

Compassionate release

59. 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 determinate sentenced prisoners are set out in Prison Service Order (PSO) 1600 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).

60. When the man was sentenced to 15 years imprisonment in June 2011, he had already been diagnosed with cancer. The guidelines for ERCG indicate that a decision to approve release would not normally be made on the basis of the facts of which the sentencing or appeal court was aware. We understand that ERCG would not usually be appropriate if the judge had passed the sentence fully aware of the extent of his illness. However, the prison had no evidence that the sentencing judge was aware of his terminal prognosis. Unless it had

been established that ERCG would have been in contradiction of the sentencing judge's intention we consider that the possibility of compassionate release should have been considered. There is no evidence that this was done.

The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure that seriously and terminally ill patients are informed about their condition and treatment and record these discussions.

   Accepted. The Palliative and End of Life Policy has been developed and is currently out for consultation. The Policy includes the expectation that patients are advised of their condition and treatment and that these discussions must be recorded on the patient's medical notes. The Policy should be fully operational by the end of March 2013.

2. The Governor and Head of Healthcare should ensure that prisoners' hospital appointments are not cancelled unless there are properly justified and recorded reasons.

   Accepted. Meetings are now held bi-monthly between a security Manager and a Healthcare Manager to plan forthcoming hospital appointments to ensure there are not unnecessary cancellations. Minutes are kept of these meetings. Should an appointment need to be re-arranged these reason are documented.

   Appointment information is now monitored at Prison Senior Management Team Meetings and the Prison Health Partnership Board.

3. The Head of Healthcare should ensure that prisoners returning from hospital appointments have a recorded assessment by healthcare staff.

   Accepted. Joint work will be undertaken with the Governor overseeing Reception to facilitate all prisoners being identified and assessed on return from all hospital appointments by healthcare staff.

4. The Governor and Head of Healthcare should implement a palliative care pathway to ensure a multidisciplinary approach for managing prisoners at the end of their lives and that full healthcare assessments take place as necessary for such prisoners, regardless of the time of day.

   Accepted. The Palliative and End of Life Care Policy includes a palliative care pathway with multi-disciplinary meetings and information sharing. Symptom scales and assessments have been adapted for use within HMP Woodhill. The Policy should be fully operational by the end of March 2013.

5. The Head of Healthcare should ensure that there is a proactive approach to pain management for prisoners with a terminal illness.

   Accepted. The Palliative and End of Life Care Policy states that all patients should have frequent assessments of pain and symptoms. Symptom scales and assessments have been adapted for use within HMP Woodhill. Where needed specialist advice has been sought from the local End of Life Care

Teams and this liaison will continue to be developed and utilised. The Policy should be fully operational by the end of March 2013.

Training is due to be delivered to healthcare staff regarding End of Life Care.

6. 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.

   Accepted. The levels of restraints required are determined by the risk assessment and approved in accordance with national policy. All prisoners leaving the establishment will be restrained I accordance with the individual risk assessment. Restraints for prisoners who are admitted to hospital are reviewed on a daily basis or when there are a change of circumstances. This will take into consideration medical reports and would be reviewed at frequent intervals for a person who is terminally ill.

7. The Governor should ensure that a family liaison officer is appointed when a prisoner is seriously or terminally ill.

   Accepted. Healthcare now advise the Safer Custody team when a prisoner is identified as a seriously or terminally ill. At this point, a Family Liaison Officer is appointed who then forms part of a multi-disciplinary approach to support the prisoner. The Family Liaison Officer meets with the prisoner and any family members to ensure any issue raised regarding care is appropriately managed and all relevant information is updated.

8. The Governor should ensure that the possibility of early release on compassionate grounds is considered and documented for all terminally ill prisoners with a short time left to live.

   Accepted. This process is now in place, with any decision on release on compassionate grounds being considered.