Investigation into the circumstances surrounding the death of a man at HMP Acklington in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Acklington. He died in April 2010 at hospital. He was 67 years old. I offer my sincere sympathy and condolences to his family and all those affected by his loss.

He was sentenced to four years imprisonment at Crown Court on 25 September 2009. He was initially taken to HMP Altcourse and after a month was moved to HMP Holme House. On 8 December, he was transferred to HMP Acklington and it was here that after complaining of chest pains he was diagnosed with cancer of the liver on 8 February 2010. It was not known at the time whether this was the primary site of the cancer or whether it had spread from elsewhere.

He began chemotherapy treatment in March but his condition suddenly deteriorated the following month and, having been transferred to hospital on 11 April, he died four days later. At the time of writing, I have not had sight of the post mortem examination but am aware that a preliminary cause of death has been recorded as stomach cancer.

The investigation was carried out by my colleague. An independent review of the man's medical care in custody was carried out by the clinical reviewer and her assistant on behalf of the local PCT. I am most grateful to them for their assistance.

I would also like to thank the Governor and staff of Acklington for their full and ready co-operation during the course of the investigation. I am especially obliged to the liaison officers for their help in liaising with my investigators.

Whilst the man was at Altcourse, the prison doctor referred him to a local hospital consultant. However, details of this referral were not entered in the continuous medical record, nor was the referral followed up when he transferred. Notwithstanding this, both my investigator and the clinical reviewer found he received a high level of clinical care whilst at Acklington. Having complained of chest pains, he was referred for appropriate investigations and a diagnosis made and treatment started within national guidelines. Furthermore, both healthcare and discipline staff at the prison displayed a great deal of compassion towards him and liaised with the hospital as appropriate. I endorse one recommendation made by the clinical reviewer regarding the introduction of a measurement tool to monitor a patient's blood pressure, pulse, pain and respiration and make one recommendation of my own.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman December 2010

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SUMMARY

Having been sentenced to four years imprisonment for a sexual offence on 25 September 2009, the man was taken to HMP Altcourse. This was his first conviction and, therefore, first time in prison. He remained at Altcourse for around a month. His only health need was identified as a Salbutomal inhaler to treat his asthma. He said he had no outstanding hospital appointments in the community. However, on 30 September, the prison received a letter with details of an appointment at hospital, following investigations which had been undertaken of his colon. Since he was now residing in a different area, the prison doctor cancelled this appointment and made a referral to the local hospital. This referral was not entered in the continuous medical record, nor was it highlighted in documentation when he was transferred. I make a recommendation in this regard.

He was transferred to Holme House on 26 October. He had no significant appointments with healthcare staff there and was transferred to Acklington on 8 December. Neither prison noted the outstanding referral following investigations of his colon when he was in the community. Nine days later, he complained of chest pain and a nurse treated him with antacid medication (used to neutralise stomach acidity). On 30 December, he told the prison doctor he was suffering chest pain again. Following a physical examination, the doctor made an urgent referral to hospital for a chest x-ray, blood tests and ultrasound scan.

On 8 February 2010, the ultrasound scan showed cancerous lesions in his liver. When the prison doctor received these results he immediately referred him to the hospital's consultant oncologist (cancer specialist). Following further tests and investigations, he started chemotherapy on 27 March. This involved him attending hospital to receive the medication by an intravenous drip and then returning to the prison where he was given oral medication twice daily for the following two weeks.

Staff at the prison monitored his condition several times a day and liaised with the hospital staff where appropriate. He was admitted to hospital for three days on 1 April and treated for a chest infection, as well as having fluid drained from his abdomen. On 11 April he was readmitted following a worsening of his condition, since he had had fallen over in the night, was vomiting and appeared dehydrated, weak and unkempt.

It was initially thought that he might have returned to prison and therefore early release on compassionate grounds was not considered. Also, an earlier prognosis had given him six months to two years to live. I find this decision entirely reasonable. However, on 15 April his condition rapidly worsened and he was assessed as being in the last stages of his life. Appropriately, prison managers ordered his restraints to be removed and his wife was contacted. She was present at the hospital, along with her sister and his son and daughter, when he died in the early hours of the following morning.

I have concluded that he received a high level of care whilst at Acklington and make only one recommendation. This is in relation to healthcare staff using a measurement tool to monitor his blood pressure, respiration, pulse and pain. I have also asked the Governor to ensure that the personal officer scheme is running as

intended, since he was effectively without a personal officer for the first and last periods of his time at Acklington. However, despite this, I found that he received the necessary support from other staff, both healthcare and discipline, such that his lack of personal officer does not seem significant.

THE INVESTIGATION PROCESS

1. The investigation was opened on 16 April 2010, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No one came forward as a result.

2. The investigator was given access to his prison files, including the medical record. She visited Acklington with an assistant ombudsman on 30 June and 1 July and interviewed five members of staff. She also met with representatives from the Independent Monitoring Board (IMB) and Prison Officers' Association (POA).

3. An independent clinical review of the man's health needs whilst he was in custody was carried out by a clinical reviewer and her assistant on behalf of the local PCT. The clinical reviewer joined the investigator for some of the interviews at Acklington on 1 July.

4. One of my family liaison officers telephoned the man's wife on 19 May to advise her of the investigation and invite her to raise any matters she wished to be addressed. She said she felt that her husband had been well cared for by the prison and that the family liaison she had received since her husband's death had been good.

5. However, his wife had two main concerns. Firstly, she wanted to know why he had been transferred to Acklington prison which was around four hours drive away from their home in Crewe. Secondly, when his health deteriorated on 15 April, prison staff telephoned her. Although she managed to see him before he died, he was not awake or aware that she was there. She said that if she had known how ill he was she would have gone to the hospital sooner. I hope that this report helps the family and friends to better understand what happened in the time leading to his death.

HMP ACKLINGTON

6. HMP Acklington opened in 1972 as a category C prison for convicted adult male prisoners. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category C prisoners are defined as those who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.

7. The prison is situated on a former RAF station near Amble in Northumberland and can accommodate 946 prisoners. This includes a vulnerable prisoner unit which holds 460 prisoners, who are considered to be at risk from other prisoners if placed on normal location. For example, if they have accumulated debts to other prisoners or committed an offence of which other prisoners would disapprove.

8. Healthcare is provided by the Northumberland Care Trust Adult Directorate. Nurses and a prison doctor (provided through a local practice) deliver primary healthcare during the daytime, seven days a week. There is no out of hours medical cover, although a doctor can be contacted by prison staff by telephone after 6.00pm. Prisoners who require inpatient nursing care are transferred to an outside hospital or another prison.

9. The then Chief Inspector of Prisons last reported on Acklington following an unannounced inspection in June 2009. She found since the last inspection in 2006, “a greatly energised and much better managed prison”.

10. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the National Offender Management Service (NOMS) and the prison’s management team. Each IMB is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.

11. Acklington’s latest IMB report covers the period July 2008 to June 2009. The Board considered that,

> “Since the new Senior Management Team arrived at HMP Acklington there have been quite a few changes. The staff morale has increased and the prisoners seem happier with their lot.”

12. The Board members had concerns about the standard of accommodation on some of the wings, the amount of purposeful activity available for those with literacy issues and delays in prisoners receiving their mail in the vulnerable prisoners unit. With regard to healthcare services, they wrote:

> “As the prison population changes and becomes older there is an increasing need to manage prisoners with illnesses associated with aging … The staff are also struggling to find appropriate consultation space within Healthcare and are constantly juggling sessions; this is restricting recruitment of extra staff who could be helping to manage the increasing

caseloads. Access to appropriate consultation rooms in which to see prisoners on the wings is also very poor, with little opportunity for prisoners to be offered confidential consultation."

13. NOMS is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Acklington has scored threes (good performance) for the last four quarters.

14. The Ombudsman assumed responsibility for investigating deaths in custody in 2004. Since that time, this office has investigated 19 other deaths at Acklington, of which 13 were due to natural causes. There are no significant similarities between these previous deaths and that of the man.

KEY EVENTS

15. The man was employed as a refuse collector for forty years. He had two children from his first marriage, aged 36 and 30 years, with whom he enjoyed a good relationship. He separated amicably from his first wife and later remarried. His second wife remained supportive of him and he intended to return to live with her in Crewe on his release from prison.

16. On 25 August 2009, he was convicted of sexual offences at Crown Court. He had no previous convictions. He remained on bail for a month, then was sentenced to four years imprisonment and taken to HMP Altcourse. As is routine on arrival at a prison, he was screened by healthcare staff and his only identified problem was long term asthma (chronic inflammatory disease of the airways) for which he was prescribed a Salbutamol inhaler. He said he had no outstanding medical appointments in the community. He was granted vulnerable prisoner status due to the nature of the offences he had committed making him potentially at risk from other prisoners.

17. Staff at Altcourse received a letter on 30 September, which said that he had an outstanding outpatient's appointment at hospital on 26 November. This was to follow up a colonoscopy (an examination of the colon with a camera) and biopsy (the removal of cells for investigation), which he had had on 29 June. In discussion with the clinical reviewer, she commented that since the follow-up appointment was five months later, this would not suggest any urgency. Since he was now in a different National Health Service area, the prison doctor cancelled the appointment and sent a referral letter to the local hospital consultant gastroenterologist (specialists in the digestive system).

18. There is no record of him being offered a hospital appointment or that this referral was followed up by the prison. Furthermore, whilst the referral letter was placed at the back of the clinical record file, its details were not noted in the continuous medical record and therefore not immediately obvious to someone reviewing his treatment.

19. Since this was his first time in prison, he was also interviewed by a Registered Mental Nurse (RMN) on 1 October. The nurse concluded that he had no mental health issues, was a low risk of suicide or self-harm and was coping well within the prison environment. No further assessments of him or significant events took place while he was at Altcourse.

20. On 26 October, he was transferred to HMP Holme House. The movements department at Altcourse explained that this was so that he could complete the sex offender treatment programme. (He was later assessed as unsuitable for this programme due to his denial of the offence.) The distance from his home was not unusual in such circumstances. Again the routine healthscreen identified his only need as a Salbutamol inhaler and he did not disclose that he had an outstanding hospital appointment in the community.

21. He had no further significant contact with healthcare staff whilst at Holme House and was transferred to HMP Acklington on 8 December. This was

because he was classed as a vulnerable prisoner and Acklington would usually be allocated such category C prisoners from Holme House. He again had a routine healthscreen, which identified his current health concerns as asthma and the need for immunisation for Hepatitis B. He was deemed fit for the gym and employment. He was concerned about the effect being located four hours away from home would have on the number of visits he received. In the next few days, he also had an elderly health assessment and an annual asthma review.

22. On 17 December, he told a nurse that he had pain in his abdomen and chest for which she gave him some antacid medication. A fortnight later, he told Prison Doctor A that his general practitioner (GP) in the community had planned to start B12 injections. As this is treatment for pernicious anaemia (a shortage of red blood cells due to a vitamin B12 deficiency), the doctor ordered blood tests. He also said that he had had pain in his right lower chest and upper abdomen and he complained of being short of breath. The doctor made an urgent referral to hospital for a chest x-ray as well as the blood tests.

23. Following the tests, abnormalities were found in his blood and on 21 January 2010, the doctor discussed these with him. He explained the results showed that there was some liver dysfunction and microcytic anaemia (meaning that the red blood cells were paler than normal which could be caused by a number of factors). He told the doctor that he had had an endoscopy (an internal examination of organs in the body) in June. He said that a lump had been found and removed on a number of occasions before his imprisonment but did not elaborate any further than this.

24. The doctor requested further information from his GP. He received information that he had undergone some bowel investigations including a biopsy, but no diagnosis had been confirmed. He said he felt well and denied losing weight despite the doctor's observation that he looked thin. As a result of this information, the doctor ordered an ultrasound scan of his liver.

25. Officer A introduced himself as the man's personal officer on 25 January. (The personal officer scheme was introduced so that prisoners are given a named officer that they can approach for advice or assistance.) He told the officer that he was happy being employed in the laundry, got on well with his cellmate and had no concerns.

26. He attended hospital on 8 February for the ultrasound scan of his liver. The results showed multiple cancerous lesions which may have been present in other organs too. They could identify little normal liver. The hospital staff typed these results on the same day as the appointment, although it is not clear when they sent them or when the prison received them. Prison Doctor A first had access to the results on 16 February, when he sent an urgent referral fax to the hospital consultant oncologist.

27. The oncologist telephoned the doctor the following day and said that he would arrange all necessary investigations and would let the prison know of appointments in advance. Later that day, the doctor discussed the scan

results with him and explained the process for onwards referral and treatment. The doctor told my investigator that from that point on he provided more of a supportive role for him, while the oncologist at the hospital directed his treatment.

28. That afternoon, Officer B visited him in his cell to find out how he was coping with the news about his diagnosis. He was very distressed and the officer arranged for him to call his wife that evening from the office telephone, so they could speak in private.

29. On 24 February, the doctor spoke to the oncologist who asked that further investigations take place in preparation for the planned outpatient appointment on 19 March. The prison also began to monitor his weight since he was having some difficulty and pain with digesting food, as well as vomiting. The oncology multi-disciplinary team at the hospital also discussed him and agreed an action plan for treatment.

30. The following day, he was assessed by the prison doctor who noted that his pain had increased and he was prescribed ibuprofen (an analgesic and anti-inflammatory). The clinical reviewer comments that this is the first treatment option recommended in the World Health Organisation (WHO) Pain Ladder. (This is a three-step scale which determines what pain relief should be given for cancer sufferers). She notes that he did not progress any further up the ladder.

31. When Officer A met with him on 6 March, he said he was coping, although anxious, and waiting to go to the hospital for more tests. He attended the hospital for a Computerised Tomography (CT) scan two days later. (A CT scan is a three dimensional x-ray). Through his own choice, he remained working in the laundry, as he felt able and preferred to occupy his time as much as he could.

32. He told the doctor on 18 March that he was having difficulty sleeping and the doctor therefore prescribed zopiclone to help with this. The following day, he attended an appointment with the oncologist, who told him he most likely had primary cancer of the bowel which had spread to his liver and lung. He was given a life expectancy of six months without treatment and two years with treatment. The consultant obtained his permission to start chemotherapy. When he returned to the prison he was tearful and was supported by wing officers and healthcare staff. He was told to contact healthcare if he had any concerns or questions. Officer A spent some time with him and he asked the chaplain to visit him.

33. On 27 March, he began chemotherapy via an intravenous drip at the hospital. His wife and son were present at the time. On his return to the prison later that day, he was moved wings so that he could have a single cell due to his increased risk of infection and lowered immune system as a result of the treatment. Although he did not want to move cells, as he had friends on his current wing, he understood why this was necessary. Later, when he started

to feel unwell following the treatment, he told staff that he appreciated having the privacy of his own cell.

34. He was also concerned that, since he had literacy difficulties, he would not know when to take his medication as he no longer had a cellmate to help him. However, Nurse A assured him that healthcare staff would keep possession of his medication and give it to him twice a day. This would take place for two weeks following the hospital treatment. Then he would have a week free of medication before beginning the chemotherapy cycle again by returning to hospital for an intravenous drip. The only medication which he kept in his possession was loperamide, which is used to treat diarrhoea.

35. The hospital gave him and prison staff a comprehensive leaflet regarding chemotherapy and its possible side effects. In addition, the prison staff were given contact details for the specialist nurse, with supporting management recommendations. He was visited several times each day by prison healthcare staff to monitor his symptoms and record his temperature. In particular, a raised temperature can be an indicator of complications for those undergoing chemotherapy.

36. On 1 April, his temperature increased. Staff immediately told the prison doctor and the oncology unit and he was admitted to hospital. The prison staff kept in contact with the hospital and he was discharged three days later, having been treated for a chest infection. He also had fluid drained from his abdomen during this time.

37. Healthcare staff in the prison continued to regularly monitor him. At times he appeared dehydrated and had episodes of nausea and diarrhoea as a side effect of the chemotherapy. The staff sought advice from the oncology unit as necessary.

38. On 11 April, at around 9.30am, Nurse A visited him in his cell. He told her that he had fallen over in the night, continued to experience nausea, vomiting and diarrhoea. He appeared dehydrated, weak and unkempt. Due to this deterioration in his condition, the nurse called an ambulance and he was admitted to hospital as an emergency.

39. As is routine when prisoners are transferred to hospital, a risk assessment was completed by healthcare staff and the security department to assess the level of restraint and number of escorts necessary for him. This assessment is based on the prisoner's current medical condition and any past behaviour which indicates they may be an escape risk. Since there were no special security measures deemed necessary for him, a governor decided that two staff would accompany him to hospital, with the use of single handcuffs. (He would be attached by one arm to an officer). One of the prison managers told my investigator that this would be the standard level of restraint for a category C prisoner. The level of restraint would be reviewed if there was any change in the prisoner's condition or if the daily management check at the hospital necessitated it.

40. Over the next few days his condition continued to deteriorate. He was transferred to the Medical Assessment Unit and then Ward 17. On 14 April, prison staff were told that the consultant was due to assess whether he could return to the prison the following day. They telephoned his wife to update her on her husband's condition and a visit was arranged for 16 April.

41. However, by the next day, his condition had worsened and he was not fully aware of his surroundings, his blood pressure was fluctuating, he was unable to eat or drink and was incontinent. Hospital staff considered that he was now in his last stages of life.

42. One of the officers with him telephoned the prison at around 2.00pm to speak to the duty governor. The officer explained that his condition had deteriorated, he was very frail and not expected to live much longer. The governor therefore spoke to the acting governing Governor. They decided to remove his restraints. The duty governor therefore asked the officer to remove the restraints and informed them a further risk assessment would follow. The man's wife was also immediately told of her husband's condition and she began the journey to see him. An officer was appointed as the prison family liaison officer (FLO).

43. Two officers took over the bedwatch at 7.30pm that evening. They received a full handover and were told of his condition. He remained asleep for the whole time the officers were there. At around 7.45pm the man's wife, sister-in-law, son and daughter arrived at the hospital. They stayed with him until around 10.00pm, when they all went to the visitor's room, apart from the son who stayed with his father, talking to the escorting officers.

44. The following morning at around 3.10am, the officers noticed that his breathing had become laboured. They called the nurse, who in turn called his family to the room. Around ten minutes later, he stopped breathing and was pronounced dead at 3.45am.

45. The officers returned to the prison where they had a debrief meeting with a governor and were offered the support of the care team. Both officers then went home around 6.00am. Two governors met the family at the hospital at 10.20am to express their condolences.

46. Following the man's death, his family were offered appropriate support by prison staff including offering to contribute to the funeral costs. The funeral took place on 26 April, without anyone from the prison attending, in line with the family's wishes. The family have been complementary about the liaison and care both they and he received from the prison.

47. Staff interviewed felt adequately supported following the death. Prisoners were also informed in a sensitive manner and a memorial service was held for him in the prison chapel on 29 April.

48. At the time of writing I have not had access to a post mortem report. I am aware that on 19 April a provisional cause of death was given as metastatic

carcinoma of stomach (stomach cancer) and an interim certificate of death by natural causes was issued.

ISSUES

Clinical Care

49. Before being imprisoned, the man had a colonoscopy in June 2009. Although he did not disclose this to staff at Altcourse, on 30 September they received confirmation of an outstanding review appointment at hospital. Since he was now residing in a different NHS area, the prison doctor cancelled this appointment and made a referral to the local hospital. Although the referral letter was placed in the back of the clinical record, the details of this referral were not entered in his continuous medical record. No note was made of this outstanding referral in the transfer documentation when he was moved to Holme House under a month later. I therefore make the following recommendation:

    The Head of Healthcare at Altcourse ensures all referrals and appointments to outside hospitals are entered in the continuous medical record. Any outstanding referrals or appointments should also be highlighted in transfer paperwork.

50. He did not tell staff about this outstanding referral when he was transferred to Holme House or Acklington. Ideally, healthcare staff would have read the referral letter in the back of the medical record and made a further referral to the local hospital. However, given this information was neither flagged up on transfer documentation nor detailed in the continuous medical record it is understandable that the referral was missed. Although I do not make a formal recommendation in this regard I would ask that the Heads of Healthcare at Holme House and Acklington ensure a prisoner's medical record is reviewed in detail on transfer.

51. In any event, the clinical reviewer told my investigator that since the review appointment had originally been scheduled for around five months after the colonoscopy, in November, this would imply the appointment was not urgent. Shortly after this appointment was due, the prison doctor had referred him to the local hospital due to his own concerns regarding his condition.

52. Having complained of chest pains to him and following abnormal blood test results, he attended an ultrasound scan on 8 February which showed cancerous lesions. The doctor referred him to the consultant oncologist on 16 February and had an appointment with him the following day. The clinical reviewer notes that this is in accordance with the Department of Health (DOH) Cancer Plan which recommends that following assessment and abnormal x-ray results a referral must be made to hospital for consultation and further investigations and the patient must be seen within two weeks.

53. His diagnosis was discussed by the oncology team at the hospital and an action plan agreed for treatment. The clinical reviewer says that this met the standards within the DOH Cancer Plan and Yorkshire Cancer Networks which is 31 days from the initial abnormal results. He began chemotherapy on 27

March which again met the DOH Cancer Plan and Yorkshire Cancer Networks guidance of a maximum of 62 days from the initial detection.

54. The clinical reviewer concludes that the hospital responded in a timely manner to a request from the prison doctor on 30 December 2009 for a consultation to a confirmed diagnosis and treatment commencing on 19 March 2010, eleven weeks later. She says that the prison doctors, in particular Prison Doctor A, were robust in making referrals and following up outcomes to meet the national standard in accordance with the DOH Cancer Plan. She writes that Prison Doctor A,

> "responded to clinical presentation, prescribing treatments, ordering investigations and making a referral to oncology. He communicated his findings to the man."

55. Prison staff communicated appropriately amongst themselves and with the hospital as necessary if his condition changed. The clinical reviewer writes that the hospital responded in a timely manner to referrals and communicated effectively with prison staff, providing support and information as required. She says that prison staff successfully monitored and supported him following his diagnosis including his blood pressure, pulse and temperature. He only volunteered that he was in pain on three occasions and was prescribed appropriate medication in these instances.

56. However, she believes that since he had told staff he was experiencing pain, she would expect staff to ask about this routinely when doing other observations. This is so that a more accurate account of any deterioration could be noted and acted upon. She comments that using a measurement tool such as the MEWS (Modified Early Warning Signs) scoring system or other validated pain assessment tools would enable staff to respond to problems earlier. She therefore makes the following recommendation, which I endorse:

The Head of Healthcare should implement a robust base line measurement tool to incorporate blood pressure, pulse, pain and respiration; for example the MEWS (Modified Early Warning Signs) scoring system.

57. In terms of palliative care, Nurse A explained that care plans would usually be put in place for prisoners and they would invite Macmillan Nurses (who provide support for cancer sufferers) to visit the prison. However, due to the sudden deterioration in his health it was not possible to organise this. However, he had been able to access support via the Macmillan Nurses at the hospital.

58. Overall, the nurse and others on the wing showed a high level of care to him, going to see him whenever they could to check on his welfare and not just when dispensing medication. I agree with the clinical reviewer that, "Overall he appears to have received a high quality of care provision".

Personal Officer Scheme

59. The man was transferred to Acklington on 8 December 2009 but was not appointed a personal officer until 31 December 2009. He therefore had over three weeks without a personal officer. It is not clear from the paperwork whether the officer had the opportunity to introduce himself before Officer A was appointed as his personal officer on 6 January 2010, following his move to a different wing.

60. Officer A introduced himself to the man around three weeks later and saw him on a regular basis over the next two months. This was in line with Acklington's personal officer scheme policy which says a minimum of fortnightly entries must be detailed on the offender's record. The officer provided him with support and encouragement at what was clearly a very difficult period in his life.

61. At Acklington, personal officers are appointed according to the wing that a prisoner is on. However, following his transfer to another wing after his initial chemotherapy treatment, on 27 March, my investigator was told by a governor that Officer A remained his personal officer. When interviewed, it was apparent that the officer was unaware of this and had assumed, as is normally the case, that the man would have been assigned another personal officer on the wing he moved to. This would be in line with Acklington's personal officer policy and a much more practical arrangement. As a result there are no personal officer entries after 19 March.

62. Nevertheless he received much support after this time, both from nurses and other officers on the wing. He also spent some time in hospital. Given this, I do not make a formal recommendation but ask that the Governor ensures that the personal officer scheme is operating effectively and in accordance with local protocol.

Removal of restraints

63. When he was admitted to hospital on 11 April, he was subject to the standard level of escort and restraints for a category C prisoner – two officers accompanying him and single handcuffs. This risk assessment was reviewed as appropriate over the following days.

64. On 14 April, prison staff were told that the oncologist was due to review him the following day to decide whether he could return to the prison. It was therefore appropriate that he remained restrained at this stage. However, his condition deteriorated rapidly on 15 April such that he was assessed to be in his last stages of life.

65. One of the escorting officers immediately contacted the duty governor at the prison who consulted the acting governing Governor. They told the officer that his restraints should be removed and this was done without delay at

around 2.00pm. This seems an entirely appropriate decision from a risk and decency perspective.

Consideration of transfer to a prison closer to home

66. He had originally been transferred to Acklington since he was a category C vulnerable prisoner and the prison has a large unit housing such prisoners. The duty governor told my investigator that under usual circumstances a prisoner could apply for a transfer to another prison after three months.

67. All staff my investigator spoke to confirmed that his condition deteriorated very quickly. Prison Doctor A said that following the results of the ultrasound in mid-February, he may have been fit for transfer. However, after that, a long journey of several hours would not have been appropriate. Furthermore, he said any transfer would have led to a disruption in his treatment.

68. The clinical reviewer agreed with the doctor's view that treatment would be disrupted by a transfer. She also highlighted that there were ten weeks from his diagnosis to his death. Therefore, she said that by the time his treatment started, the symptoms were so advanced that the prognosis was not optimistic and transfer to another prison would have been difficult for him. She also said that the unpredictability of lung and liver cancer made it very difficult to know how quickly the disease would progress.

69. Given these circumstances including the sudden deterioration in his health, it seems reasonable that he was not transferred to a prison closer to home.

Consideration for early release on compassionate grounds (ERCG)

70. Prison Service Order (PSO) 6000 says ERCG may be considered when

> "a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison."

71. In order to apply for ERCG, a form must be completed by a registered medical practitioner with details of the medical condition, the seconded probation officer with details of the care available in the community and the Governor with details of the risk the prisoner presents. This is then forwarded to the Public Protection Casework Section (PPCS) at Prison Service Headquarters, who will obtain the opinion of a medical director, prison health and the Parole Board, as necessary. A decision to release can only be made by Ministers and is usually made within two weeks, but can be more quickly if circumstances require it. The PSO also says that if there is a medical

application involving a very short life expectancy, the PPCS must be alerted by telephone at an early stage.

72. Staff my investigator spoke to said that his condition had deteriorated too quickly for ERCG. The prison doctor understood that in mid-March he had been given a life expectancy by the oncology consultant of six months without treatment and two years with treatment. He started chemotherapy at the end of the month but was admitted to hospital for three days at the beginning of April and received treatment for a chest infection. He was then admitted again as an emergency on 11 April. However, it is clear that initially it was thought he may return to the prison. It was not until 15 April, the day before he died, that his condition deteriorated rapidly and the hospital confirmed he was in the end stages of his life.

73. Since his initial prognosis was six months to two years, an ERCG could not be completed at this stage. His condition then deteriorated very quickly on 15 April. It is clear that a full application for ERCG could not have been completed in time at this stage but in line with the above guidance a telephone call could have been made to the PPCS to alert them to his condition. However, it is unlikely to have made any significant difference for him and I therefore do not make any formal recommendation in this regard. I would, however, ask the Governor to ensure that staff are aware of the contents of PSO 6000 in relation to consideration for ERCG.

CONCLUSION

74. The man entered prison a reasonably well man, apart from a diagnosis of asthma which was well controlled with medication. It later became apparent that while in the community he had undergone investigations of the bowel, including a biopsy to which no diagnosis was confirmed.

75. Having been transferred to Acklington in December 2009, he complained of chest pains later that month and was quickly referred by the doctor for further investigations. After cancerous lesions were found in his liver, he started chemotherapy on 27 March and a high level of care and liaison with the hospital was shown by prison staff. Unfortunately, the following month, having been admitted to hospital, his condition deteriorated very suddenly and he died, with his family present, in the early hours of 16 April.

RECOMMENDATIONS

1. The Head of Healthcare at Altcourse ensures all referrals and appointments to outside hospitals are entered in the continuous medical record. Any outstanding referrals or appointments should also be highlighted in transfer paperwork.

   This recommendation was partially accepted and the response is below:

   "A checklist is conducted by nursing staff the afternoon prior to transfer; this included outstanding hospital appointments. The checklist is attached to the envelope that contains the print out of the medical record and was in place at the time of transfer.

   Admin staff will scan all appointments onto systm1 as soon as they are received and a copy will go with the print out of the medical record."

2. The Head of Healthcare should implement a robust base line measurement tool to incorporate blood pressure, pulse, pain and respiration; for example the MEWS (Modified Early Warning Signs) scoring system.

   This recommendation was accepted and the response is as follows:

   "HMP Acklington Healthcare have adapted the MEWS (Modified Early Warning Signs) score that is used in the general hospitals. It is a robust baseline measurement tool which will incorporate blood pressure, pulse pain and respiration."

FAMILY COMMENTS

The man's wife asked for the following comments to be added to the final report:

> She was upset that the prison doctor cancelled the appointment at hospital without checking why it was needed. Also, that it was not entered into the record and followed up when he transferred to another prison. She feels both caused an unnecessary delay in the diagnosis and care he received.
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> When he attended the hospital to hear his diagnosis he had to ask the doctor at the hospital to call his to inform her – she therefore found out by phone that he had little time to live which was very distressing. She feels she should have been allowed to attend this appointment with him to offer him support as they were aware in advance that he was to receive news of the diagnosis.
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> When his family attended the hospital to be with him for his chemotherapy it was most upsetting to see that he was handcuffed and chained – this drew attention to him and remarks from other people at the hospital – it was also obvious how ill he was as he could barely walk. Thankfully, the officers removed the chains as they were in the way of the attached drips but it was upsetting that they were there in the first place.
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> She visited her husband at the prison one further time after the chemotherapy. This was the last time she saw him where he was awake and able to speak to her. She spoke of how hard it was to have this visit in the normal visits area. Firstly because he was so weak walking there was hard for him. He had sickness and diarrhoea so had to leave the room for a long period. He looked so unwell again it drew attention to him which was humiliating for him. She feels that he was so ill that a private room should have been arranged for this visit.
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> She was upset to see that the hospital staff were aware what he was in prison for as it states that female staff were not comfortable treating him and male staff had to do so instead. This is judgmental and she does not know how they knew his offence and he deserved to be treated as like any other person.
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> From reading the nurses interview it seems that not enough information was recorded in the medical notes as the nurse did not seem to know much despite having them in front of her – she thinks everything should be recorded in these documents.