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 July 2013 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 the investigation report into the death of a man at hospital in July 2013 while in the custody of HMP Woodhill. He died from malignant mesothelioma (a cancer caused by asbestos exposure). He was 65 years old. I offer my condolences to his family and friends.

A clinical reviewer conducted a review of the clinical care the man received in custody. The prison cooperated fully with the investigation.

The man had been in prison since 2009. In September 2011, he was diagnosed with cancer and underwent palliative chemotherapy. In May 2012, he was given a prognosis of three to six months but outlived this. In December 2012, he was placed on an end of life care plan. He moved from his wing to the prison's healthcare unit in April and remained there until his health deteriorated. He was taken to hospital on 28 June and died there several days later. I do not consider that the use of restraints when he was taken to hospital was always fully justified by an appropriately considered risk assessment, a matter I have raised with Woodhill before.

While it does not appear that the current physical facilities at Woodhill are entirely suitable for end of life care, I share the clinical reviewer's view that the overall standard of healthcare provided at Woodhill was at least equivalent to that which the man could have expected to receive in the community.

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 **January 2014**

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SUMMARY

1. On 31 March 2011, the man was sentenced to 18 years imprisonment for serious offences. He had been at HMP Woodhill while on remand and remained there when he was sentenced. This was his first time in prison.

2. In August 2011, the man was referred to hospital after experiencing episodes of shortness of breath. He was diagnosed with malignant mesothelioma (a cancer caused by asbestos exposure which occurs in the lining of internal organs) the following month. He had chemotherapy treatment between October and December 2011.

3. The man received a prognosis of three to six months in May 2012, but outlived this. In December, he was placed on an end of life care plan. Over the following months his health deteriorated and, in April 2013, he moved from his wing to the healthcare unit at Woodhill.

4. The man was taken to hospital on 28 June after it became apparent that he was in the final phase of his illness. He died in hospital in July.

5. We conclude that the man received appropriate medical and end of life care at the prison. However, we make recommendations about the facilities for providing palliative care, risk assessments for the use of restraints and the need for swift consideration of applications for compassionate release.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and inviting anyone with relevant information to contact him. No responses were received.

7. A clinical reviewer was commissioned to assess the standard of the man's clinical care in prison.

8. The investigator visited Woodhill on 5 July and obtained copies of the man's prison and prison medical records. He met the deputy governor, visited the healthcare wing where the man had lived and met healthcare staff. He spoke to a friend of the man's on one of the wings. He met members of the Independent Monitoring Board (IMB), a POA union representative and the family liaison officer. The investigator and clinical reviewer interviewed prison staff in October and provided feedback to the Governor about the initial findings of the investigation.

9. HM Coroner for Milton Keynes was informed of the investigation and provided a copy of the post-mortem. The Coroner has been sent this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's wife to explain the purpose of the investigation and invite his family to identify any relevant matters for the investigation to consider. She asked whether he should have been released on compassionate grounds and, while she understood the constraints of prison custody, asked whether his family should have been allowed to visit him in prison more often. She was also concerned about his access to oxygen and the regularity of his appointments with doctors.

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.

12. The man's family received a copy of the draft report. Their comments have not led to any factual changes in this report.

13. The service also received a copy of the draft report. Their response to our recommendations and action plan is included in this report.

HMP WOODHILL

14. HMP Woodhill has the dual role of a local prison and a high security prison and holds more than 800 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.

15. Central & North West London NHS Foundation Trust delivers health services at Woodhill. The healthcare unit has 15 rooms for inpatients, including a larger room for disabled prisoners.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) conducted an unannounced inspection of Woodhill in January 2012. The Inspectorate found that the range of health services did not meet the needs of the population because of high levels of staff vacancies and sickness. 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

17. Each prison has an Independent Monitoring Board 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 2012 annual report, the IMB were concerned about the longstanding shortage of healthcare staff, which meant that the range of healthcare services did not meet the needs of prisoners. The IMB said that the needs of older prisoners were well met and the inpatient unit was described as calm, bright and spacious. The IMB did not comment on palliative care services.

Previous deaths at Woodhill

18. The man was the sixth prisoner to die at Woodhill since December 2011. One previous death also involved a man diagnosed with a terminal cancer when we were concerned about the compassionate release process and the use of restraints, matters we raise again in this report.

ISSUES

The Diagnosis of the man's terminal illness

19. On 18 August 2011, a prison GP examined the man after he reported feeling short of breath. He told the doctor that he had been experiencing similar symptoms for around three weeks. The doctor recorded that he had been exposed to asbestos in the past and was at risk from asbestosis (cancer caused by prolonged exposure to asbestos) and recommended an urgent chest X-ray.

20. At a surgery the next day, the man also told another prison GP that he had previously been exposed to asbestos. The doctor examined him and noted that he had limited air entry to the right side of his lung. He diagnosed a pleural effusion (collection of fluid around the lung) and requested a chest X-ray.

21. The man went to hospital on 20 August for an X-ray and then moved to another hospital in Oxford on 24 August for a pleural biopsy (removal of tissue from around the lung) after the discovery of a large pleural effusion. The results of the biopsy showed that he had malignant mesothelioma.

22. Under national NHS guidelines, any cases of suspected cancer should be referred to a specialist urgently and the patient should be seen by a specialist within two weeks. We are satisfied that the man was appropriately referred and that his cancer was diagnosed quickly.

Informing the man about his condition and treatment

23. On 19 September, the man attended a clinic at the hospital with a consultant chest physician, who told him that the results of the biopsy showed he had malignant mesothelioma.

24. A nurse saw the man when he returned to the prison that day and recorded that he was tearful. They discussed how the news would affect his wife. He said he wanted to return to his wing where he felt he would be supported. He later discussed his illness and treatment options with wing staff and said that he had been given a prognosis of 6-12 months.

25. Between October and December 2011, the man had chemotherapy treatment at hospital. His medical records show that he had frequent contact with healthcare staff at the prison during this period and was well supported.

26. On 16 January 2012, the man told a prison GP that he was aware he had a terminal illness but was unsure of his prognosis. The doctor wrote to an oncologist at hospital to request an appointment for the man to discuss his concerns. There is no record that the appointment was made, and his next recorded contact with his consultant was in March 2012. However, at the end of January he was referred to the Macmillan cancer support service and received support from a specialist in palliative care from the beginning of

February. Prison healthcare staff told us that he was given information about cancer and palliative care after his diagnosis and that he had frequent contact with staff and understood his condition. Although the records are less frequent for the time after he completed his chemotherapy, we are satisfied that, with the additional support of the Macmillan service, the prison kept him kept informed about his condition.

The man's medical appointments and treatment

27. On 27 September 2011, an oncologist (cancer specialist) at hospital saw the man and advised palliative (symptom-relieving) chemotherapy. A prison GP spoke to a nurse at the Macmillan unit at the hospital the next day to discuss his treatment plan. The nurse told the doctor that the man would have four sessions of chemotherapy and provided a written treatment plan on 6 October.

28. The man had chemotherapy between October and December 2011. The oncologist wrote to the prison to keep them updated on the progress of his treatment. His medical records show that he had frequent contact with medical staff at the prison during this period. On 13 December, he told prison staff that his chemotherapy was being stopped as it was of limited benefit.

29. In March 2012, the man had a scan to find out the progression of his disease. An oncologist at the hospital met him on 15 May to discuss the results and gave him a prognosis of 3-6 months.

30. After his diagnosis, the man had at least 20 hospital appointments. On three occasions his visit was delayed or cancelled and rescheduled because he questioned the suitability of the transport provided, although healthcare staff were satisfied that it was appropriate. We are satisfied that these delays did not impact significantly on the quality of care he received.

31. The clinical reviewer notes that the man received chemotherapy and associated healthcare as directed by the oncology team and records no complications or difficulties. He concludes that his treatment was equivalent to that he could have expected to receive in the community.

32. In August 2012, the man began oxygen therapy (breathing high concentrations of oxygen from a cylinder or machine) to help with his breathing difficulties and continued this treatment for the rest of his life. There are a number of entries in the medical records where he complained to staff that the oxygenator (breathing device) was not effective, and the machine was replaced. An engineer checked the equipment, but did not find any fault. He was advised how to use the machine and given hand-held oxygen cylinders when he said that the oxygenator was not working properly.

33. Two prison doctors told us that the man's oxygen saturation levels remained normal despite these problems. The clinical reviewer considers that appropriate action was taken when he questioned the effectiveness of his oxygen therapy.

The man's pain relief and medication

34. The man's pain relief was managed through a number of pain killers including morphine sulphate, morphine, pregabalin and paracetamol. During the early stages of his illness, he frequently complained of delays in receiving anaelgesic medication and its effectiveness. In June 2012, he told wing staff that he had not received medication for 12 hours. There were also some delays recorded in him receiving pain relief during the night while he was living on the wing.

35. The prison primary care lead told us that due to a lack of nursing staff at night, it was hard to provide controlled drugs (which prisoners cannot keep in their possession) quickly to the man when he was on the wing, but that this was much easier to manage once he moved to the healthcare unit. She acknowledged that there could have been some delays in administering medication at night but said it was unlikely that he would not have been offered pain relief for 12 hours as he was also receiving regular medication for other conditions.

36. Specialist staff from the Macmillan hospice provided ongoing advice on pain relief throughout the man's illness and noted that he sometimes chose not to take his full prescribed dose of medication to try and control his pain and symptoms independently. The palliative care specialist noted that he was worried about suffering side effects from morphine and could not be reassured about this.

37. Records show that the man's analgesia was frequently reviewed and adjusted by healthcare staff. He was involved in multi-disciplinary discussions about his pain relief and advised about pain management. At a meeting of staff responsible for his care in December 2012, he was recorded as saying that his pain was being managed well.

38. As the man's illness advanced, he suffered from oedema (fluid retention) in his upper and lower body which caused increasing pain and affected his mobility. He was treated with furosemide (to remove fluid) and adjustments were made to his cell on the wing to help with pain relief.

39. The clinical reviewer notes that there was some difficulty in establishing an effective pain management regime for the man, and that this was complicated by him deciding to reduce his medication contrary to specialist advice, which was not conducive to effective pain relief. The clinical reviewer concludes that the management of his condition by the prison health care team was appropriate and that his analgesic regime was more effective once he moved from the wing to the healthcare unit.

40. In the light of the clinical reviewer's comments, we are satisfied that the man's medication and pain relief was adequately managed. However, we are surprised that, when he was on the wing, the possibility of issuing him with pain relief medication in his cell to self-administer overnight and return next

morning, which we have seen happen in other prisons, does not appear to have been considered. It is possible to supply medication to a terminally ill prisoner at night after lock up and collect it again the next morning without a significant security risk.

Location

41. When the man was diagnosed with a terminal illness, he lived on Housing Unit 4B (HU4B), a residential wing for vulnerable prisoners which houses most of the prison's older and disabled population. He had a carer on the wing to help him with daily tasks. As his illness progressed, he was given a larger hospital bed and a pressure-relieving mattress and a cushion for his bed. Grab rails were installed to aid mobility. The primary care lead told us that these adjustments were transferred to his cell in the inpatient unit when he moved there. He was issued with a zimmer frame, and later a wheelchair, as his mobility decreased.

42. The man was frequently offered a move from his residential wing to the healthcare unit by staff during his illness but always declined. The primary care lead said that he felt more comfortable on the wing, where he was closer to friends.

43. On 2 April, a multi-disciplinary decision was made that it was no longer appropriate for the man to live on a residential wing as he needed 24 hour dedicated care. This was explained to him and he was moved to a single cell in the healthcare inpatient unit.

44. The man was initially disappointed to have been moved from the wing but settled into his new location. He remained in the inpatient unit until his condition deteriorated to the extent that he needed specialist treatment in hospital. He went to hospital on 30 May for four days. He was re-admitted on 28 June, as he was nearing the end of his life. He remained at the hospital until his death in July. The primary care lead said that a move to a local hospice had previously been considered but was never possible as his condition did not stabilise sufficiently to allow for him to be cared for at the hospice.

45. We are satisfied that the man was properly involved in frequent discussions about his location and was allowed to remain on a residential wing in accordance with his wishes until it was no longer possible to manage his treatment needs there effectively.

46. In the medical records, there are a number of references to the difficulties healthcare staff faced in treating the man in his cell. A palliative care specialist, who was part of the man's care team, said that the physical environment of the cell made it difficult to provide care safely and could result in staff injury.

47. Healthcare staff told us they were concerned about the lack of a suitable environment in which to provide palliative care in the prison. The primary care

lead said that staff needed a hoist to move the man as his mobility decreased but that this would not fit in the cell. Although there was a larger more suitable cell on the unit adjusted for prisoners with disabilities, this cell was occupied by such a prisoner during his illness. She said that she had completed a Serious Incident Report after his death, recommending another large cell in the healthcare inpatient unit.

48. The clinical reviewer notes that adequate facilities at Woodhill are limited as the prison was built at a time when there were fewer older prisoners with intensive health care needs. While the prison considered other possible locations for the man's care and moved him to hospital when he needed more specialist care, it is apparent that the current facilities at Woodhill are not fully suitable to accommodate the needs of seriously ill and immobile prisoners at the end of their lives. We make the following recommendation:

The Governor should ensure that terminally-ill prisoners who require intensive palliative care are treated in a suitable environment.

Palliative care plans

49. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway is that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

50. On 26 January 2012, the man was referred to Macmillan cancer support services from the local hospice after his chemotherapy treatment had finished. The palliative care specialist assessed him for the first time on 6 February and said that he had responded well to chemotherapy. Staff from the hospice had frequent input into discussions about his care and treatment during the course of his illness. The level of specialist involvement increased as his condition deteriorated.

51. On 15 May 2012, the primary care lead saw the man to discuss his prognosis and arranged a review of his care and treatment regime on 20 June. At the review, the palliative care specialist said he was happy with the care he was receiving at the prison.

52. In August, the man was placed on an 'activities of daily living' care plan to ensure regular reviews of issues related to the management of his condition. After the care plan was implemented, he received more frequent interventions from prison healthcare staff and outside agencies.

53. On 19 December, at a multi-disciplinary discussion about his care the man said that he would want to be resuscitated in the event of a respiratory or cardiac arrest. On 28 December, he was placed on an end of life care plan (a

multi-disciplinary care plan covering all aspects of a patients care and treatment) and a family liaison officer was appointed.

54. On 29 March 2013, a doctor discussed resuscitation options with the man again. He recorded that he understood that any attempt to provide cardiopulmonary resuscitation (CPR) would now be unlikely to succeed due to his terminal illness and other health problems. He agreed to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which was appropriately recorded.

55. As the man's condition deteriorated, nurses began to check him daily and reported back to daily staff briefings as part of his care plan. On 31 March, a nurse was assigned to the wing to perform hourly observations during the night and the increased level of support was formalised in a daily routine care plan. After he moved to the healthcare unit on 2 April, extra nurses were assigned during the day and a second nurse at night to help manage his care.

56. The clinical reviewer concludes that the man was involved in the management of his condition when important decisions were made about his care. He commends the health care team for developing and implementing changes in care delivery for prisoners with palliative and terminal care needs. As we have made previous recommendations to Woodhill about the provision of palliative care, we are pleased to see that improvements have been made. We agree with the clinical reviewer's conclusion that his palliative care was managed appropriately.

Contact with the man's family

57. Prison Service Instruction (PSI) 64/2011 says that prisons should encourage terminally ill prisoners to engage with their families and must ensure that arrangements are in place for an appropriate member of staff to liaise with the next of kin or nominated person and, with the prisoner's agreement, keep them updated on the prisoner's condition.

58. The man and his family received some support from the prison chaplaincy. In August 2012, the chaplaincy made arrangements with a church in the local community for his wife to be given pastoral support. In December 2012, he and his wife renewed their wedding vows in the prison chapel.

59. On 19 December 2012, a trained family liaison officer (FLO) was appointed. She introduced herself to the man on 21 December and met members of his family on 23 December. She saw him and his family frequently over the next few months and dealt with any questions and concerns they had about his care.

60. In May 2013, as the man became more immobile, the FLO arranged for his family visits to take place in a room closer to his cell in the healthcare unit. In June 2013, when his health deteriorated significantly, she arranged for family visits to be increased from one a week to three. When he was in hospital towards the end of his life, family visits were extended to reflect normal

hospital visiting hours. While some prisons facilitate daily visits at the end of life, we are satisfied that the arrangements made were adequate.

61. After the man's death, another trained FLO continued contact with the family as the first FLO was not at work. In line with national guidance, the prison contributed to the funeral and arranged a memorial service at the prison which his wife attended.

62. The primary care lead told the investigator that prisoners at Woodhill are now assigned a family liaison officer when they are first diagnosed with a terminal illness. While it would have been best practice to appoint a member of staff to liaise with the man's family earlier, we are satisfied that the prison supported his contact with his family and ensured that he was able to see them more frequently as his health deteriorated. The clinical review notes that his next of kin was kept informed at key stages of his illness.

Compassionate release

63. 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 permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. 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 must be supported by the Governor and submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

64. The man's offender supervisor told us that he was first considered for early release in October 2011 after his legal representative made an application. She told us that the application was concluded and refused on 26 October by the Head of the prison's Offender Management Unit. The prison was unable to provide us with any documentation about this application.

65. In March 2012, the offender supervisor asked an operational manager to review the application after the man's wife asked about it. On 1 May, the operational manager wrote to the man's wife to say that he had started the process of considering early release and, on 3 June, told her that the application was being progressed. On 25 July, after a query from the man's MP about the progress of the recommendation, one of the operational managers told PPCS that the application had been sent back to the prison's offender management unit for more information as it was incomplete.

66. The offender supervisor told us that she received sporadic requests for information from the man's offender manager (probation officer in the community) between May and July. She contacted senior managers on 24 October to find out what was happening and was told that the application was

with the operational manager for consideration. On 26 October, another operational manager concluded the application and did not recommend compassionate release, citing the risk of reoffending. She told us that she had received the application about two days before she made her decision.

67. In January 2013, the offender supervisor requested an update on behalf of the man and was told that the application was not due to be reviewed. The operational manager said that the man had not submitted a further formal application and there had been no significant change in his circumstances to require a further review at that stage. A custodial manager asked the offender supervisor to provide a further submission in May 2013 when his condition had deteriorated. She told us that she thought release on temporary license (ROTL) to a hospice was being considered but was unaware what had happened to the application before he died. The operational manager said the possibility of temporary release had been discussed with healthcare staff, but a move to his home or a hospice was not deemed suitable.

68. While the man received an answer to his application some time before his death, this is because he lived beyond his original prognosis. We are concerned that it took seven months, from March 2012 to October 2012, to respond to the application. We are satisfied that the application was given appropriate consideration and do not question the eventual conclusion, but this was too long. The staff we spoke to were unclear about what had caused this delay and the reasons are not clearly documented. It is important that applications for early release on compassionate grounds are dealt with quickly when prisoners are diagnosed with a terminal illness, particularly when they have a relatively short life-expectancy. We make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are fully documented and completed without delay.

Restraints, security and bed watch

69. When prisoners are taken outside prison, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

70. The Prison Service has a duty to protect the public when escorting prisoners to hospital and has a responsibility to balance this by treating prisoners with humanity and 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. 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 a 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 to be regarded as inhumane unless justified by other relevant considerations.

71. The man went to hospital at least 20 times after he was diagnosed with a terminal illness. Restraints were used for every visit, including when he was receiving chemotherapy between October and December 2011. On these occasions, he was double-cuffed and an escort chain was used while he was receiving treatment. (Double cuffing means that two pairs of handcuffs are used, one to cuff the prisoner's wrists in front of him and one to cuff one of his wrists to that of an officer. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) His risks were recorded as either medium or low for these visits. The risk assessments from healthcare staff gave no medical objections to the use of restraints rather than commenting on how or whether his medical condition reduced his risk.

72. On 30 May 2013, the man went to hospital because of his deteriorating health. A nurse completed the medical section of the risk assessment and noted that he was terminally ill. She did not comment on his risk or indicate whether there were any medical objections to the use of restraints. A security officer assessed him as a medium risk to the public and of having outside assistance to escape. All other risks were considered low, including risk of escape. It was noted that he was terminally ill and that his wife was visiting him in hospital that afternoon. The assessment concluded that staff should use double-handcuffs for the escort, but this was reduced to a single handcuff by the duty governor, who noted his medical condition.

73. An escort chain was used while the man was in hospital. During this time, he had swollen hands but staff decided that the escort chain should remain on as it could be swapped between his wrists. Restraints were removed when he had a scan.

74. The man was admitted to hospital for the last time on 28 June, when he was diagnosed by a doctor as being in the terminal phase of his illness following a significant deterioration in his health. He was recorded as having reduced levels of consciousness and was unable to self-mobilise. A nurse completed the medical section of the risk assessment and gave no medical objections to the use of restraints. No further information was given regarding his condition. A security officer recorded that all of his risks were low. At 1.50pm, the duty governor instructed that an escort chain should be used because of his physical pain. Later that afternoon, at 5.05pm, the next duty governor agreed with the escort staff at the hospital that the restraints could be removed.

75. Prison Service guidance is that restraints are not normally necessary for an escort when a prisoner's mobility is severely limited. By the time the man went to hospital on 30 May, his health had deteriorated significantly. He was suffering from significant oedema and was using a wheelchair. The primary

care lead told us that all staff in the prison would have been aware of his medical condition. While we recognise that restraints were eventually removed at hospital, it is difficult to see how their use was justified to take him to hospital or on earlier occasions when he was receiving chemotherapy treatment.

76. Discussions with staff at Woodhill indicate little awareness of the requirements of the 2007 High Court judgement or the subsequent Prison Service guidance issued by the Head of Security Group in April 2008. It is a requirement that prisoners' state of health is accurately assessed and fully recorded in the risk assessment to ensure that appropriate levels of restraint are used. This is a matter we have raised with Woodhill before.

77. There is a need for all those involved in making decisions to ensure that a prisoner's health and mobility are fully recorded and taken into account in risk assessments for hospital escorts. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff involved in risk assessments for prisoners being taken to hospital are fully briefed about the implications of the 2007 High Court Judgement and take it into account when deciding the level of security needed for hospital escorts.

RECOMMENDATIONS

1. The Governor should ensure that terminally-ill prisoners who require intensive palliative care are treated in a suitable environment.

2. The Governor should ensure that all applications for early release on compassionate grounds for prisoners with terminal illnesses are fully documented and completed without delay.

3. The Governor and Head of Healthcare should ensure that all staff involved in risk assessments for prisoners being taken to hospital are fully briefed about the implications of the 2007 High Court Judgement and take it into account when deciding the level of security needed for hospital escorts.

ACTION PLAN: The Man – HMP Woodhill

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that terminally-ill prisoners who require intensive palliative care are treated in a suitable environment.	Accepted	All prisoners who are deemed to be terminally ill are monitored regularly by healthcare professionals, they currently consider both the wishes of the individual as to his ongoing location, and his ongoing medical needs. The prisoner's location is subject to review by senior healthcare professionals, medical officer, and senior management team on a daily basis to ensure that the prisoner receives the best medical care possible whilst in custody. The current location of Healthcare inpatients is currently subject to review and relocation or alteration to buildings is being considered by the Governor and head of works.	30 April 2014	
2	The Governor should ensure that all applications for early release on compassionate grounds for prisoners with terminal illnesses are fully documented and completed without delay.	Accepted	A policy to be implemented by Head of Offender Management Unit in conjunction with Offender Managers and external partners to ensure that applications are completed without delay. Both medical and risk of reoffending to be considered.	31 January 2014	
3	The Governor and Head of Healthcare should ensure that all staff involved in risk assessments for prisoners being taken to hospital are	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 have restraints applied In accordance with	31 January 2014	

	fully briefed about the implications of the 2007 High Court Judgement and take it into account when deciding the level of security needed for hospital escorts.		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. Meeting to be held by Head of Security, Head of Safer Prisons and Equality and Head of Healthcare to produce an updated risk assessment.		