
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death of a man at HMP Preston in August 2012**

Our Vision

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

This is the report into an investigation into the death of a man at HMP Preston in August 2012. He was 75 years old. A post-mortem examination found that he died from metastatic rectal carcinoma. I offer my condolences to his family and all those who knew him.

The investigation was conducted. The local PCT commissioned a clinical review of the man's healthcare, which was undertaken by a clinical reviewer. Staff at HMP Wymott, HMP Preston and HMP Altcourse cooperated fully with the investigation.

In 2009, the man was diagnosed with rectal cancer and had chemotherapy treatment but declined radical surgery. In March 2010, he had some polyps removed. On 3 June, he was sentenced to seven years imprisonment and sent to HMP Altcourse. A hospital appointment for 18 June, to remove a further polyp, was cancelled by Altcourse and it was planned that he would be referred to a local hospital. Before this was arranged, he transferred to HMP Wymott, on 7 July.

There was an unacceptable delay between the man arriving at Wymott and his referral to a local hospital, despite his partner alerting the prison. Eventually the polyp was removed in January 2011. Further scans revealed that his cancer had spread to his lungs. He again declined surgery, but completed several courses of chemotherapy. In May 2012, a scan revealed his cancer had spread to his brain and he was told this was inoperable. When he left hospital he went to HMP Preston where he received palliative care until he died in August. Apart from the delays and one occasion at Preston when he was given the wrong medication, the clinical reviewer is generally satisfied that he received a level of care equivalent to that he could have expected in the community.

While there is no evidence that delays affected the outcome for the man, I am concerned that Altcourse cancelled a planned operation without making alternative arrangements. This led to an unnecessary delay in his treatment, exacerbated by Wymott's failure to make a further appointment, even when alerted by his partner. It is clear that his partner made strenuous efforts to ensure that he was given treatment when he required it. Indeed, had it not been for those efforts, he would not have received the treatment when he did. Both Wymott and Preston failed, at various times, to communicate with her effectively at a time of great stress. Finally, it is disappointing that we once again have to recommend that Wymott conducts appropriate risk assessments before using restraints on seriously ill prisoners.

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

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SUMMARY

1. In 2009, the man was admitted to hospital suffering from rectal cancer and was treated by chemotherapy and radiotherapy. He was advised to have surgery to remove the remaining cancer but he declined, even when he was advised the cancer was not cured and would return. He was offered further chemotherapy which he also declined.
2. In March 2010, the man had a rectal operation and three polyps were removed. A further polyp needed to be removed and an appointment was made for him to return on 18 June for this procedure. Before this could take place, he was sentenced to seven years imprisonment on 3 June and initially sent to HMP Altcourse.
3. At Altcourse, the man's hospital appointment was cancelled because of the distance involved and his imminent transfer to HMP Wymott to serve his sentence. The GP responsible for this decision intended to refer him locally and he should have stayed at Altcourse until the appointment took place, but before this occurred he was transferred to Wymott on 7 July.
4. The man's partner sent letters to Wymott including information about him waiting for an operation to remove a further polyp. In July, at his partner's request, his GP in the community sent a letter to Wymott about his condition and his Member of Parliament (MP) also contacted the prison.
5. The Head of Healthcare saw the man on 9 November 2010, to discuss a letter of complaint from. After this discussion, information from the hospital in Wales where he had been treated was sought immediately, resulting in a hospital referral on 15 November.
6. The man was seen by consultants four months after arriving at Wymott and referred for surgery. He had the remaining polyp removed in January 2011. In February, it was found that the cancer had spread to his lungs but he again refused to have any sort of operation, even though he was told that if his cancer progressed he could be beyond surgical treatment. He agreed to chemotherapy, which helped to reduce the size of the tumours.
7. The man was frequently seen by consultants. He had blood and urine tests and regular scans to check his progress and condition. On 1 May 2012, a scan revealed the disease had progressed and, following a fall and emergency admission to hospital on 19 May, a further scan revealed his cancer had spread to his brain and was inoperable. He received brain radiotherapy but this was ineffective.
8. On 2 June, the man moved to Preston prison as it has 24 hour health care. Compassionate release was considered but he decided he wanted to remain at Preston. He died in August.

THE INVESTIGATION PROCESS

9. This office was notified of the man's death on 17 August 2012. Notices about the investigation were displayed inviting anyone with relevant information to contact the investigator. No response was received.
10. The investigator visited HMP Preston and HMP Wymott on 28 August and collected relevant documents about the man. He visited the Healthcare Centre at Preston where the man had died and spoke to members of staff there.
11. One of our family liaison officers contacted the man's partner to inform her of the purpose of the investigation and to allow her the opportunity to identify issues that she wanted the investigation to consider. She had the following concerns:
 - She said she spent seven or eight months trying to get Wymott to refer him to hospital for the removal of an outstanding polyp, including contacting her MP. She had written to the prison six times asking for him to be referred but only received either unsatisfactory responses or none at all. By the time he eventually had the operation the cancer had spread to his lungs.
 - When he was finally referred he was seen by a specialist via a video link so no blood tests were carried out.
 - Even when the spread of the cancer was diagnosed there were further delays at the hospital. She considered that his care fell below the care he would have had in the community.
 - When he was moved to the hospital she had visited him twice before being told she could not visit any more as she was only allowed two visits. Her MP told her she was entitled to see him every day and the prison then allowed this. By the time she found this out she was only able to have a few more visits. She said that if this had been made clearer sooner, she would have been able to see him more.
 - When he was taken to hospital he was handcuffed and chained despite being so ill he could hardly walk.
 - Liaison with the prison was very poor in the last week of his life. When he moved to HMP Preston, she found it difficult to get information about how he was. The last time she saw him conscious was on the Saturday before he died. The next day, Sunday, was the first day he had not telephoned her so she was very worried. She had tried to find out how he was but the officers she spoke to would not put her call through to healthcare or find out for her. It was not until the next Friday that the prison called her to say he was seriously ill. He died soon after she arrived at the prison.

- When she saw him just before he died he looked asleep but was writhing in pain. He was then administered morphine. His partner was concerned that he did not get adequate pain relief soon enough.
12. A clinical review of the man's healthcare was undertaken by a clinical reviewer. The investigator contacted Her Majesty's Coroner to inform him of the investigation and to obtain a copy of the post-mortem report. A copy of this report has been sent to the Coroner.
 13. On 24 October, the investigator returned to Preston and Wymott. Together with the clinical reviewer, he interviewed a nurse at Preston and an administrator, a nurse and the current healthcare manager at Wymott. Because of a technical problem, the interviews were not recorded.
 14. This version of the report has been amended following feedback on the draft report.

HMP PRESTON

15. HMP Preston is a local prison holding up to 842 remanded, unsentenced and convicted adult male prisoners. Healthcare is provided by a Care Foundation Trust. The healthcare unit has inpatient facilities which are used as a regional facility for up to 30 prisoners with mental and physical health problems. There is a full-time doctor between 9.00am and 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area and at night and weekends there is on-call cover.

Previous deaths at Preston

16. There have been 10 deaths at Preston since 2007, four from natural causes. None of the circumstances of the previous investigations are similar to those in this case.

Her Majesty's Inspectorate of Prisons report

17. HM Inspectorate of Prisons made an unannounced short follow up inspection of Preston in April 2012. Inspectors noted that an appropriate range of health services were provided, primary care services had improved and inpatient services were satisfactory, with an improved regime for the prisoners there.

Independent Monitoring Board (IMB)

18. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. In the Preston IMB's annual report covering the period 1 April 2011 to 31 March 2012 the IMB noted,

“Over the last 12 months we have had a number of ‘end of life’ patients who have been looked after on the healthcare facility in their final months of life and in 2 cases we have been commended for providing a service that is better than those which are available outside of the prison.”

HMP ALTCOURSE

19. HMP Altcourse is a category B local prison in Liverpool, receiving prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by a private company and holds up to 1,324 sentenced and remand adult and young adult males. Altcourse is made up of seven house blocks divided into individual units. These units hold between 60 and 95 prisoners.
20. The private company also provides the healthcare at the prison. There is a 12 bed in-patient facility that has a care suite and provides 24 hour medical cover from nurses and doctors.
21. HM Inspector of Prisons last carried out a full unannounced inspection of Altcourse in January 2010. The Inspectorate found that Altcourse was an extremely effective local prison and that healthcare services were adequate,

but at the time were affected by staff shortages. Inspectors commented that “there were links with local palliative care agencies, but we were unaware of any palliative care policy”.

22. In the latest report published by the IMB at Altcourse for July 2011 to June 2012, the IMB commented that, in their opinion, the general healthcare provided within the prison met the standards which prisoners could reasonably expect in the community.

HMP WYMOTT

23. HMP Wymott is a category C prison holding up to 1,174 adult male, sentenced prisoners. Healthcare services at Wymott are commissioned and provided by a Care Foundation Trust. There are no inpatient beds, and prisoners requiring inpatient care often go to HMP Preston. GP services are provided by a private company with clinics held every weekday.

Her Majesty’s Inspectorate of Prison’s report

24. HM Inspectorate of Prisons made an unannounced short follow up inspection of Wymott between 15 and 17 November 2011. In his introduction, the Chief Inspector said:

“There had been good progress in health care and health care staff were well integrated into the prison. However, prisoners were still negative about health care provision and this was mainly due to long waits to see the GP and dentist.”

Independent Monitoring Board (IMB)

25. In their annual report for 2011/12, the Wymott IMB commented:

“The Board remains concerned at the current arrangements for GP services at HMP Wymott. The Board considers that a locum agency service cannot provide the degree of consistency demanded by the particular healthcare needs of the prisoner population. The Board urges the Foundation Trust to implement an appropriate solution without delay.”

Referring to reception and induction for newly arrived prisoners it said:

“Prisoners arrive with a sealed plastic package containing their documentation. However it appears that these often contain incorrect documentation or have important items missing; for example cell-sharing risk assessments, health care information, outstanding hospital appointments and ACCT documents. This causes an immense amount of unnecessary work and frustration as officers attempt to verify information with the sending prison, and often delay the decisions as to whether Wymott is able to accept the prisoner.”

Previous deaths at Wymott

26. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, we have investigated 35 deaths at Wymott, of which the majority were due to natural causes. This is, in large part, due to its older population profile compared to most prisons. In two recent reports, we made a recommendation about the use of restraints. We repeat that recommendation here.

KEY EVENTS

27. On 2 February 2009, the man was admitted to hospital suffering from rectal cancer. On 14 May, chemotherapy and radiotherapy was completed and he was advised to have radical surgery to remove the remaining cancer. He declined, as he did not want a colostomy. He was told that the cancer was not cured and would return. On 27 July, he was offered further chemotherapy which he also declined.
28. On 5 March 2010, the man had another operation on his rectum. Three sessile polyps (abnormal growths of tissue with a risk of malignancy) were removed and sent for examination. Another polyp remained and an appointment was made for him to return on 18 June for further surgery.

HMP Altcourse

29. On 3 June 2010, the man was sentenced to seven years imprisonment. During his reception interview it was noted he was very low in mood and he was made subject to suicide and self-harm monitoring through an ACCT plan (Assessment, Care in Custody and Teamwork.). This was closed the next day. He saw a nurse, who noted that he smoked ten cigarettes a day, had been in prison before and was not disabled. He had recently seen a doctor and had undergone chemotherapy. He said he had no outstanding medical appointments. He asked to see a doctor about medication for his knee and joints, but could not recall the medication he was taking. He said he had received anti-depressants in the past, and had been thinking about harming himself. He said he had asthma and chronic obstructive pulmonary disease (COPD, a lung disease). He was given vulnerable prisoner (VP) status because of the nature of his offence and was admitted to the healthcare unit overnight.
30. The man saw a doctor, who noted 'He has/had bowel cancer.' The doctor also noted that he used inhalers and took tramadol for joint pain, but was unsure of the dose. The doctor found that he had no current problems or disability and found him to be fit for work and the gym. He prescribed him with ipratropium bromide and salbutamol inhalers (for COPD), ibuprofen (an anti-inflammatory) and paracetamol (pain reliever).
31. The following morning the man saw a doctor, who noted his long standing COPD. He told the doctor that he had no previous history of depression or other mental health problems. The doctor found him to be rational and communicative with good eye contact. His mood appeared flat but he did not express any thoughts of self-harm. The doctor referred him to a mental health nurse for assessment.
32. A doctor asked an administrator to contact a consultant at the hospital to cancel the man's appointment for 18 June, as he thought it was too far for him to travel. He asked for all relevant records to be forwarded so he could arrange another appointment elsewhere.

33. A doctor saw the man 12 June. He told the doctor he felt his chest got tight when he walked up the stairs, he was producing small amounts of sputum and he was a smoker. The doctor noted he looked well, had no shortness of breath and his chest was clear. He diagnosed COPD, gave smoking cessation advice and added a steroid inhaler to his medication. The doctor noted that he should be reviewed by the asthma/COPD nurse three weeks later.
34. On 17 June, a doctor noted on SystemOne (the computerised medical record) that he had received the documents from the hospital. He recorded that the man suffered from low rectal cancer which had been diagnosed in February 2009, and had received treatment but declined surgery. The doctor then recorded that he had a colonoscopy in March 2010, and had been due for another on 18 June 2010. The doctor recorded that he planned to refer him to colorectal surgeons at a nearby hospital. No restriction on any future transfer (known as a medical hold) was put in place in the meantime.

HMP Wymott

35. On 7 July, the man was transferred to HMP Wymott. A nurse noted that he suffered from COPD, smoked nine cigarettes a day and wanted to stop, and he had no thoughts of self harm. He told the nurse he had had cancer of the bowel and had received both chemotherapy and radiotherapy. He gave consent for her to obtain information from his consultant. She listed him for an urgent appointment with a doctor to discuss whether he should be referred locally. She also referred him to a smoking cessation advisor. Because of his poor health, particularly his COPD, he was assessed as not fit for work and in need of a lower bunk in a cell on the lowest landing.
36. A doctor saw the man on 12 July and noted his history of COPD, chronic back pain and sciatica. She prescribed salbutamol to be inhaled, a beclometasone inhaler, spiriva inhalation capsules with a handihaler and tramadol tablets. After reading his medical record, the doctor asked a medical administrator to telephone the hospital to check if they had a referral pending for him. They said that they did not.
37. On 13 July, a letter reached healthcare from the man's partner, who was concerned that his cancer was not being taken seriously. That day, she wrote to his community GP asking him to write to Wymott about his cancer, which he did. She also saw her MP on 24 July to express her concerns and, on 4 August, visited him at Wymott. After this visit, she wrote another letter to Wymott (received on 10 August) about his health needs.
38. A doctor saw the man on 19 August. He told the doctor that he had been light-headed and had fainted a few times when getting out of bed, was still wheezing but had no headache or any further symptoms. He was still smoking. The doctor noted some wheezing in his lungs. He diagnosed asthma and advised him to go to the smoking cessation clinic. The Primary Care Manager saw him for his annual COPD review on 2 September. A week later he declined a hepatitis B immunisation vaccination.

39. On 12 November, the Primary Care Manager spoke to the man about a letter of complaint written by his partner. He said he wanted a follow-up examination for his bowel cancer, which he had never received. He gave her a full history, which she confirmed with his community GP. She asked for a copy of his medical record to be sent to her and arranged for a referral to be completed by a doctor at Wymott, which was carried out on 17 November.
40. On 20 December, the man saw a consultant gastroenterologist at hospital. The consultant told Wymott that the man had no bowel symptoms at that time, but he had requested another flexible sigmoidoscopy (examination of the intestine) and would see him again once this had been performed. He told the man he might be referred to the colorectal surgeons if cancer follow-up was needed.
41. On 13 January 2011, the man attended the hospital for the sigmoidoscopy which found another polyp in the rectum which showed moderately differentiated adenocarcinoma (malignant tumour). The consultant referred him to a colorectal surgeon at another hospital.
42. On 3 February, the man's partner wrote to Wymott thanking them for arranging for him to have his polyp removed. On 16 February, he saw a specialist registrar in the surgeon's clinic. He told her that he did not have any altered sensation in his rectum, his bowels were normal and he was not passing any blood. He was adamant that he did not want an operation for his rectal cancer. He was aware that, if his cancer progressed and he began to have symptoms, surgery might no longer help but said he would be willing to consider chemotherapy. The registrar checked his bloods and arranged for him to have an MRI scan which uses electromagnetic radiation to obtain images of the body's soft tissues.
43. The man had an MRI scan on 25 February, which revealed a significant nodule in his right lung and non-specific small mediastinal lymph nodes. On 2 March, a CT scan identified a mass in his left lung. It was concluded that this was likely to be metastatic disease (spread of a disease from one organ to another non-adjacent organ).
44. On 23 March, the surgeon told the man that his rectal cancer had recurred, and he had a mass in his left lung that was likely to be a tumour. He was still firm that he did not want any surgery but would consider palliative chemotherapy and the surgeon made a referral.
45. A consultant oncologist saw the man on 3 May and confirmed that the rectal cancer had spread to his lungs. He told him he would require palliative chemotherapy and recommended another CT scan.
46. On 28 June, the man saw the consultant oncologist for the results of his CT scan, which showed that the mass in his lung had increased in size. However, there were no other features of disease progression. They agreed that palliative chemotherapy at that time would not be in his best interests.

The consultant said he would review him again in three months unless he developed further symptoms.

47. At the beginning of August, the man gave up smoking. He saw the consultant oncologist again on 16 August and told him that he felt well and had no specific symptoms. He continued to eat well. The consultant explained that chemotherapy would not improve his quality of life and there was no evidence from his recent scan that there was a rapid rate of disease progression. He agreed with the plan and understood that chemotherapy was still a treatment option. The consultant also explained that, if required, he would recommend combination chemotherapy which carried a greater risk of toxicity. He again declined surgery, the only potentially curative treatment option, although this was regarded as unlikely to be successful. The consultant arranged for a further CT scan six weeks later.
48. The consultant oncologist reviewed the man on 27 September and 12 October following CT scans. They agreed that he should start chemotherapy treatment on 21 October. Healthcare staff liaised daily with chemotherapy nurses for updates on his condition. He saw the consultant on 8 and 22 November, and 20 December.
49. The Primary Care Manager received a phone call from the man's partner on 4 January 2012, as she was concerned that his pain medication had been stopped. In fact, the prescription had expired and was being rewritten. He continued to receive his pain medication.
50. On 17 January, a nurse saw the man, who complained of increased frequency of urination. She took a urine sample but found nothing abnormal. She considered referring him to an urologist for a possible prostate problem but, as he was undergoing palliative treatment, she discussed the options with him and asked him to decide whether he wanted to be referred.
51. The consultant oncologist reviewed the man on 31 January 2012. Another CT scan showed the cancer was responding to treatment and had reduced in size. The consultant explained this to him and recommended further chemotherapy. He saw a nurse on 2 February. He told the nurse that he had decided he would like to be referred to the urologist.
52. On 19 February, a nurse at Wymott received a telephone call from the man's partner, who said that he was extremely unwell. The nurse spoke to him and he told her that he was wheezy and expectorating green phlegm and had felt unwell all week but had not informed anyone in healthcare. The next day, a doctor diagnosed an acute upper respiratory infection and prescribed prednisolone and amoxicillin. When reviewed on 28 February, the consultant oncologist noted that he remained well and was tolerating his chemotherapy with no significant problems.
53. The Primary Care Manager contacted the man's partner on 19 March, after receiving a letter expressing concern that he was not attending hospital for appointments. She reassured his partner that he had appointments for

urology and oncology. He attended oncology the following day and the consultant oncologist again noted that he remained well.

54. As the man was having problems with nocturia (frequent passing of water overnight), a telemed consultation (by video link) was arranged for 27 March. He spoke to a consultant urologist, who concluded it was possible that some of his symptoms were related to radiotherapy induced bladder changes. He advised that he should change to decaffeinated drinks and be prescribed an anticholinergic (which block nerve impulses, including in the urinary tract).
55. On 30 March, a doctor noted in his medical record that he was waiting a letter of advice from the consultant urologist about the man's medication. On 2 April, Primary Care Manager spoke to the man's partner about the telemed appointment and told her they were still waiting for the consultant to advise them about the medication. An administrator chased this on 3 April and again on 10 April. The Primary Care Manager contacted the hospital again on 11 April but they were unable to access the letter as the consultant's secretary was on leave. She then spoke to the manager to express her concerns. The consultant's recommendations were received shortly afterwards.
56. The man submitted a complaint the next day about the delay in receiving treatment for his urology problem. A nurse sent an apology to him, explaining that the consultant urologist's recommendations had only been sent the day before, and that the medication had now been ordered from the pharmacy. On 19 April, he requested a copy of his medical record (which he received on 10 May). On 25 April, he saw a nurse for a review of his medication and to discuss his complaint.
57. The consultant oncologist saw the man again on 1 May. A CT scan showed that the mass in his left lung had grown and other pulmonary lesions had also increased in size. He decided he wanted to begin second line chemotherapy. The consultant decided it would be easier to administer this as an inpatient at hospital and began making suitable arrangements.
58. The man's partner telephoned Wymott again on 18 May, as she was concerned about his health. He had told her that he was in pain and that his leg was swollen, but that he had not spoken to any healthcare staff about these symptoms. His partner was concerned that the swelling in the leg could be the result of a blood clot.
59. On 19 May, the man's partner visited him. He told her that his legs kept giving way and that his head did not feel right. Later that day, a nurse was called to the wing as he had fallen on the stairs and had a small bump to the back of his head. He said he had felt dizzy and his legs had given way underneath him. He had normal power in his upper limbs and to his right leg, but no power in his left leg. The nurse took his observations. He said he had no pain in his leg or hip but was unable to bear weight. She decided to send him to hospital by emergency ambulance as she noted similar symptoms to a stroke. A risk assessment concluded that his risk of escape and reoffending was medium. He was restrained using an escort chain.

60. At the hospital, the man had a CT scan but nothing was seen and he was admitted for more tests. An MRI scan of his brain indicated that he had multiple brain metastases (known as secondary cancer, which is a cancerous growth at a site remote from that of the original malignant tumour).
61. On 21 May, a doctor told the bedwatch team (escorting prison officers) that the man's condition was serious and his next of kin should be informed. She was informed and visited him the next day, and again on 23 and 31 May. [In her response to the draft report, she said that she had called the prison on 20 May, as he had not spoken to her, and was told that he was ok and they would ask him to call her. He did not. She received a telephone call late the next day asking her to attend the hospital as soon as possible.]
62. The Nurse Manager at Wymott visited the man in hospital on 24 May, and spoke to him and hospital staff regarding his condition and plans for his care. The next day he was moved to a different unit where he remained in a stable condition. A consultant oncologist saw him on 31 May, discussed the results of his MRI scan and explained how radiotherapy could help improve symptoms. He then arranged for him to have five treatments of whole brain radiotherapy as an outpatient from 5 June.
63. The man was also referred to the Palliative Care Service. (Palliative care is provided when patients will not recover from their illness, but receive treatment to reduce the severity of their symptoms.) Following a review by a Registrar in Palliative Medicine, he was told that, because of the brain metastases, his prognosis was likely to be shorter than previously thought.
64. The man's condition meant that he needed 24 hour inpatient healthcare after he was discharged from hospital. As Wymott has no inpatient facilities, it was arranged for him to be transferred to the inpatient unit at Preston prison.

The man's time at HMP Preston

65. The man arrived at Preston on 2 June, after he was discharged from hospital. He was located on H2, the part of the healthcare unit for people with physical health problems. His observations were recorded daily and a nursing care plan was opened and reviewed regularly.
66. On 21 June, the man slipped and fell over in the shower room. He was offered a cell with a hospital bed but he did not want to move. A doctor examined him and noted he had moderate pitting oedema (excessive build-up of fluid leading to swelling) to both ankles and prescribed furosemide (a diuretic) tablets. He decided to monitor his prostate by testing his PSA (prostate-specific antigen, a type of protein produced almost exclusively by the prostate gland) every three to four weeks. He diagnosed steroid induced hyperglycemia (high blood sugar), gave him six units of novorapid (insulin) and had his blood monitored regularly to help adjust the novorapid.

67. Both of the man's legs were dressed to secure and reduce the oedema and he was given plimsolls and advised to elevate his legs. Special hosiery stockings were ordered.
68. A doctor saw the man on 22 June and talked to him about his raised BMs (Boehringer Mannheim test, a blood test performed using a glucose meter) and hyperglycaemic disorder. He said he felt well in himself, slightly light-headed but otherwise fine. The doctor increased his novorapid, informed nursing staff to monitor his BMs twice that evening and take his blood pressure. His lower leg swelling became more settled and the doctor explained to him that the likely cause of his raised BMs was the dexamethasone (given to counteract certain side effects of antitumor treatment). They agreed to reduce this.
69. On 26 June, the man discussed his future treatment and care with a clinical nurse specialist in palliative care from a hospice palliative care team. He said he was happy with his care and would let nurses know if his needs changed. The next day staff at Wymott began the process of applying for compassionate release. They requested written confirmation of his prognosis from his consultant and asked his offender manager (probation officer) to see what accommodation and support would be available if he was released.
70. Over the next few weeks the man's oedema cleared up, he took his medication regularly, his blood glucose levels were checked and his observations were taken daily. He had regular visits from, and made phone calls to, his partner. On 11 July, he was informed by his consultant oncologist that the radiotherapy for his brain metastases had not worked well and he was given a life expectancy of three to six months.
71. On 25 July, the man told a healthcare support worker that he had a lack of energy, trouble getting up from the bed to use the toilet and no strength in his arms. A doctor saw him, who said he had a band-like headache when he woke up and had stopped taking his cocodamol and paracetamol tablets as he felt nauseous. The doctor noted that his left ankle was swollen with mild pitting oedema. He told him to keep his legs elevated as much as possible and to take paracetamol as needed.
72. On 27 July, the man was found on the floor of his cell. He was uninjured and lifted himself up onto his bed. His partner visited him next day but after his visit he was unable to get out of his wheelchair and was helped to his bed. On 29 July, he had a settled day, was mobile and cared for himself.
73. A doctor examined the man again on 30 July. He noted that he was a bit wobbly on his feet and that his legs were swollen and thought that he might have DVT (deep vein thrombosis). He ordered blood and urine tests and prescribed clexane (an anticoagulant used to prevent and treat DVT). The tests indicated that his creatinine (a break-down product of creatine phosphate in muscle) was below normal range, and he asked the hospital to arrange a venogram (an X-ray of the veins using a special dye, used for judging diagnostic imaging methods for DVT).

74. The man went to the hospital on 2 August but staff were unable to conduct the venogram as they could not insert a cannula (small tube) into his foot because of the oedema. Instead, on 6 August, they arranged for him to have a Doppler ultrasound (where sound waves are used for visualizing body structures and can diagnose DVT). This showed that he had DVT in his left popliteal vein (a vein located behind the knee). A doctor saw him on 8 August and noted that he was feeling increasingly tired every day, was generally frail and had a lack of energy. The next day, it was noted that he was becoming increasingly frustrated as he was losing his independence and needed more help with daily tasks.
75. On 10 August, the man was seen by a doctor, who advised that he might benefit from hospital admission, but he decided to stay at the prison. The doctor prescribed continuous oxygen therapy and changed his pain relief from codeine to tramadol. The doctor noted that a meeting was being arranged to discuss resuscitation with the man and his partner.
76. That evening the man saw a doctor again as staff were concerned he was drowsy and deteriorating. The doctor found that he was aware of time and place and had understanding and capacity. The doctor told him that he could change his mind and be admitted to hospital. His observations were then monitored every two hours. Staff were told that, if he became drowsy and unwell and did not have capacity, they were to call for an ambulance.
77. On 11 August, the man's observations were recorded overnight and during the day. He was unhappy at being disturbed and did not want to eat. He accepted a move to larger cell with a hospital bed, and then ate and drank. A palliative care plan was in place to make him as comfortable as possible.
78. On 13 August, the man refused the offer of a pressure mattress to make him more comfortable and reduce pressure sores. He saw a doctor, who noted that he was orientated and engaged in conversation, had dry lips and mouth and did not feel like eating but was taking fluids. He said he did not have any pain and just felt tired. They discussed whether he should be resuscitated in the event of a cardiac arrest. He agreed he did not want to be resuscitated and he understood the implications of this decision. The doctor then signed a Do Not Attempt Resuscitation Order. He said that he had no family and gave the doctor permission to discuss his prognosis with his partner as she could not visit before the end of the week. The doctor noted that the care plan was to keep him comfortable. He then asked if he could try a pressure relief mattress, which he was then given.
79. A consultant in palliative medicine met prison medical staff on 15 August to discuss the man's end of life care. A doctor and a nurse felt he had noticeably deteriorated in the previous two weeks. Compassionate release was again discussed but the process was not completed before his death. [Since the publication of the draft report, his partner has forwarded a letter about compassionate release from his solicitor. In the letter it states that the Governor at Wymott had informed him that early release on compassionate

grounds was not considered appropriate at that time. This was not evident from the prison records viewed by the investigator.] She had told the nurse that, even if he could be released, she did not feel that she would be able to care for him. [In her response to the draft report, she said that the nurse had told her that he would require round the clock, professional, care.] They also discussed hospice and hospital care. However, he said that he wanted to end his life in prison and reiterated his decision about not wanting to be resuscitated. A doctor spoke to the man's partner by telephone to update her about his prognosis.

80. On 16 August, the man slept for long periods and remained on continuous oxygen therapy. At 5.19pm, a nurse noted that she had given the man another prisoner's medication (atenol, which lowers blood pressure) in error. She immediately told him and her manager and completed an incident form. A prison doctor was informed. He advised that he should be observed every two hours and that he should be contacted if his condition deteriorated.
81. The man was observed overnight and answered coherently when spoken to. However, at approximately 4.45am he started shouting and holding his head. His oxygen saturation was found to be 56 – 67% (very low) and he appeared confused saying his head pain was an eight out of a maximum ten. His oxygen was increased and his oxygen saturation level increased to 97%. His oxygen was then reduced to four litres via an oxygen mask. He said he had no head pain, and was no longer confused.
82. At 8.20am, a palliative care nurse saw the man. She thought that he was presenting with terminal restlessness and gave him an injection of midazolam (a sedative). A doctor saw him at 9.36am when he stated he had no pain, although nurses noticed intermittent restlessness and agitation. His intake of food and drink had reduced significantly and end of life medication was begun. He was kept comfortable. At 10.20am, he refused fluids saying he just wanted to sleep but was worried. He was given reassurance and made comfortable.
83. At 11.00am, the palliative care nurse gave the man a further dose of midazolam as he had remained unsettled and was thrashing around his bed, groaning and agitated. At 12.00pm she noted he continued to remain unsettled, grabbing at his head. She gave him some diamorphine (an opiate-based painkiller).
84. At 3.29pm a doctor reviewed the man. As he was obviously in pain, he increased the diamorphine and midazolam. He also asked the healthcare management team to ask district nurses to set up a syringe driver (to continuously administer analgesics).
85. The man's partner arrived at 6.00pm to visit him. She consulted with the doctor at 6.40pm as previously arranged. At 6.45pm, district nurses arrived to set up a syringe driver. At 7.15pm, he appeared to stop breathing. A doctor attended and confirmed death at 8.10pm. A prison family liaison officer was

appointed and liaised with the man's partner. In line with national guidance an offer towards funeral costs was made.

86. A consultant pathologist performed a post-mortem examination on the man on 23 August. He gave the cause of death as metastatic rectal carcinoma.

ISSUES

Clinical care

87. When he arrived in prison, the man had an outstanding appointment for a sigmoidoscopy at a hospital. This was cancelled by Altcourse on the recommendation of a doctor, because of distance to the hospital. However, no alternative appointment was made before he transferred to Wymott and Wymott was not made aware of the outstanding action. It was not until his partner expressed her concerns that an appointment was made some months later.
88. Non-routine hospital appointments should not be cancelled without alternative arrangements being made. In this case, it was a particularly significant appointment relating to the man's on-going treatment for cancer. When a prisoner is due to be transferred but still has treatment outstanding, they should stay at that prison until the appointment is completed (this is known as a medical hold). In this case, as another appointment had not been made, there was no medical hold. He was then transferred to Wymott without an alternative appointment resulting in a lack of continuity of care. We make the following recommendation:

The Head of Healthcare at Altcourse should ensure that prisoners' appointments with hospital consultants are not cancelled unless alternative appointments are arranged and that transfers to other prisons do not take place until the appointment has taken place or the prisoner can attend from the new prison.

89. There was a delay after the man arrived at Wymott before he was referred to another hospital. He was not referred locally to an oncology consultant by a doctor, although a nurse had made an appointment with the doctor for this to be considered, after his healthscreen. Healthcare checked only to see if he had an outstanding appointment at a hospital near Altcourse, but there was no further consideration of whether he should be referred to a local hospital. It was five months after he arrived at Wymott that he was finally referred, and this was only after his partner had made several complaints.
90. It is unacceptable that a prisoner should wait so long for a key appointment to be arranged. Although it was unfortunate that the man was moved from Altcourse before treatment was arranged at a hospital, it was apparent that the nurse was aware that a further appointment needed to be made. She referred him appropriately for a GP review for that purpose. Although it was established that there was no treatment plan in place, no follow up action was taken. We make the following recommendation:

The Head of Healthcare at Wymott should ensure that prisoners with serious ongoing conditions have appropriate treatment plans and are referred to consultants as necessary.

91. It took several letters of complaint from the man's partner before he was seen by the Head of Healthcare and had his treatment reviewed in November 2010. (She had been appointed Head of Healthcare after the previous person had left Wymott in the middle of September.) It is apparent that had his partner's complaint of July 2010 been properly investigated, he would have received treatment earlier, (although it is not clear whether this would have altered the eventual prognosis). We make the following recommendation:

The Governor and Head of Healthcare at Wymott should ensure that all complaints about healthcare treatment are registered, acknowledged and investigated appropriately and promptly.

92. The man was given another prisoner's medication in error on 16 August while at Preston. This should not have happened but did not contribute to his death. The nurse immediately told him and her manager what had happened and completed an incident form. The doctor was informed, and the man, who was not concerned, was kept under observation. The nurse confirmed that she had not checked his identification as she should have done before administering medication, in line with national guidelines. The clinical reviewer could not find any evidence that this incident was investigated or that any lessons discussed with staff. We make the following recommendation:

The Head of Healthcare at Preston should introduce a system to ensure that all nurses follow correct procedures when administering medication, and that investigations are conducted when errors are made so that lessons learnt are promulgated to staff.

93. When the man was having problems with nocturia, a video link consultation was held on 27 March 2012. He spoke to a consultant urological surgeon at Airedale General Hospital (in Keighley, some 40 miles from Wymott). Video link consultations can be an effective way of ensuring patients receive prompt appointments and do not have to travel unnecessarily. The clinical reviewer did not have any concerns about this consultation being conducted by video link. However, healthcare staff at Wymott were not informed promptly of the proposed treatment plan, or the medication the consultant urologist recommended. We are satisfied that staff at Wymott made appropriate attempts to obtain this information, but it is unfortunate that there was a further delay in his treatment.
94. The clinical reviewer found that all other policies and procedures were followed. Apart from the delays in receiving treatment and the issuing of the wrong medication, the reviewer found that the care the man received was equivalent to that he would have received in the community.
95. The man's partner was concerned about the amount of pain that he was in when she visited him. The clinical reviewer has, however, not noted any concerns about the management of his pain, and has commented that the team at Preston worked with him to make him as comfortable as possible during his final illness.

Use of restraints

96. 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.
97. Whenever the man attended hospital appointments, he was risk assessed. On each occasion, including his hospital admission on 19 May 2012, he was assessed as being a medium risk of escape and was escorted by a minimum of two officers and restrained using an escort chain. The chain was removed when he received treatment at hospital. Every risk assessment contained the phrase "This man has the ability to escape". In a previous case of a death at Wymott in July 2012 we were told that healthcare staff always assess prisoners as a risk of escape regardless of the prisoner's state of health.
98. The man's partner has pointed out that, on his last admission to hospital, he was so ill he could hardly walk. On 19 May, he was admitted to hospital as the nurse thought that he might be having a stroke. In both of these circumstances, it would seem highly unlikely that he had the ability to escape from two bedwatch officers and yet an escort chain was used to restrain him.
99. In another recent investigation into a death of a Wymott prisoner, we commented that "the prison is reluctant to consider allowing a prisoner out, unrestrained, regardless of age or infirmity. The large elderly population at Wymott is judged in the same way as a physically fit and active younger prisoner and no effective individual assessment is made". As a result, we recommended that the Governor and Head of Healthcare ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff. Wymott accepted this recommendation, and noted that healthcare staff were receiving training on how to conduct risk assessments.
100. We welcome Wymott's acceptance of this recommendation, but this is not just a matter for healthcare staff who do not make the decisions about the level of security for hospital escorts. Managers are ultimately responsible for ensuring that escort arrangements comply with the legal requirement to balance security with humanity. We therefore repeat our recommendation:

The Governor and Head of Healthcare at Wymott should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

Liaison with the man's partner

101. The man's partner said that, when he was taken to hospital, after she visited him twice she was told that she could not visit him again. (Prison visits are usually twice a month.) After she raised the matter with her MP she was told that she could visit him every day. Because she had not been told this sooner, she was not able to visit him as often as she would have liked.
102. Preston's policy ("Domestic visits on bedwatch") was issued in 2007. In the policy, it is stated that no visits will be allowed for the first 72 hours, that all visits must be booked 72 hours in advance using the usual visits booking system. The only exception to this is when a prisoner's medical condition is considered critical, when visits can be approved by the duty governor.
103. It is apparent that there was a breakdown in communication between the prison and the man's partner, and that the outcome was that he received fewer visits than he might otherwise have done. His condition was serious enough for his partner to be allowed to visit within the first 72 hours, and the prison should have ensured that she was given appropriate information about when she could visit, and how often.
104. The man's partner also told the investigator that she thought that she should have been informed earlier that his condition had deteriorated, as this meant that she only saw him shortly before he died. After he had failed to telephone her as usual, she said that she had tried to find out how he was, but that her calls were not put through to healthcare.
105. Prison Service guidance (PSI 64/2011) PSI PSI/62/2011 says 'Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill'. The PSI comments that "With the prisoner's agreement, the family should be kept informed and updated on the prisoner's condition particularly if there is deterioration in their condition". Preston did not appoint a family liaison officer until after the man's death and we consider that an earlier arrangement would have helped ensure that his partner was given appropriate information about visits and his condition and would have provided a single point of contact for her in the prison. We make the following recommendation:

The Governor of Preston should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to discuss and take forward contact with the prisoner's family in line with the prisoner's wishes.

RECOMMENDATIONS

To HMP Altcourse:

1. The Head of Healthcare at Altcourse should ensure that prisoners' appointments with hospital consultants are not cancelled unless alternative appointments are arranged and that transfers to other prisons do not take place until the appointment has taken place or the prisoner can attend from the new prison.

NOMS accepted the recommendation and commented:

Appointments that require cancellation will be re arranged accordingly and offenders who have outstanding appointments will not be transferred unless agreement has been reached with the receiving establishment that they can facilitate the appointment.

In exceptional circumstances and the transfer is required for Security purposes, HMP Altcourse will make arrangements to accommodate the appointment.

To HMP Wymott:

2. The Head of Healthcare at Wymott should ensure that prisoners with serious ongoing conditions have appropriate treatment plans and are referred to consultants as necessary.

NOMS accepted the recommendation and commented:

Healthcare at Wymott have reviewed their reception process, consent for previous medical records is obtained.

During reception any prisoners that are identified to have been on medical hold at the sending establishment would be discussed with prison governor with a view to sending them back until the outstanding appointment had been facilitated.

Any follow up of appointments with consultants or outside agencies are an action to be completed by the admin department immediately after reception.

3. The Governor and Head of Healthcare at Wymott should ensure that all complaints about healthcare treatment are registered, acknowledged and investigated appropriately and promptly

NOMS accepted the recommendation and commented

All complaints or letters of concern are logged onto the prison or healthcare system retrospectively, and directed to the most appropriate member of staff to respond.

Within healthcare the correspondence is scanned onto the clinical system and electronically tasked to the appropriate member of staff to respond. Comments are recorded within the clinical records regarding any action taken with copies of all correspondence.

All complaints or letters of concern are logged by the business management unit and directed to the appropriate member of staff to respond within the specified time scale

4. The Governor and Head of Healthcare at Wymott should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

NOMS accepted the recommendation and commented:

The Head of Healthcare has undertaken an audit of 10 further risk assessments and PER forms. Following the audit, the Head of Healthcare in consultation with the Head of Security has formulated an action plan which includes raising awareness of healthcare staff via team briefings, the development of examples of completed risk assessments for healthcare staff to refer to for guidance and the reception nurse delivering further training to all nursing staff involved in completing risk assessments.

Sample checks of completed risk assessments and PER forms will be conducted on an on-going basis to ensure continued compliance and consistency.

Decisions to apply restraints are made taking full account of the information contained in the healthcare risk assessment, security information and any dynamic factors that need to be considered at the time.

To HMP Preston:

5. The Head of Healthcare at Preston should introduce a system to ensure that all nurses follow policies and procedures when administering medication, and that investigations are conducted when errors are made so that lessons learnt are promulgated to staff.

NOMS partially accepted the recommendation and commented:

HMP Preston accept that there is a need to ensure that all nurses follow policies and procedures when administering medication and that investigations are conducted when errors are made so that lessons learnt are promulgated to staff. However, on this occasion an internal investigation into the medication error **was** conducted in line with LCFT policy and all the appropriate reporting mechanisms were followed (Datix etc).

6. The Governor of Preston should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to discuss and take forward contact with the prisoner's family in line with the prisoner's wishes.

NOMS accepted the recommendation and commented:

HMP Preston accepts the need to appoint an FLO when a prisoner is diagnosed with a terminal illness. However, they feel that the report does not reflect how well they worked together in delivering end of life care for the man. Contact was regular with his NOK & as he was located on healthcare, staff there were the liaison with the family.