

**Investigation into the circumstances surrounding
the death of a man at
outside hospital
in September 2011,
whilst in the custody of HMP Shepton Mallet**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2012

This is the report of an investigation into the circumstances of the death of a man who died in September 2011 at outside hospital. He was 76 years old. A post mortem confirmed that he had died of carcinomatosis (a condition where cancer has spread widely through the body) and cancer of the rectum. I offer my condolences to his family and friends.

The investigation was led on my behalf by an investigator. One of my family liaison officers contacted the man's family to explain the investigation process and learn of issues they wished to raise.

A review of the man's care while in custody was commissioned by Somerset Primary Care Trust and was carried out by a clinical reviewer. The man had kept his symptoms to himself for some considerable time and, sadly once they became apparent, the condition was inoperable. He received appropriate palliative care at outside hospital.

The clinical reviewer found that the healthcare provided to the man in custody was generally of a good standard and comparable to that he would have received in the community. However he was concerned about the lack of the National Screening Programme for bowel cancer at the prison, and ineffective communication between healthcare staff and doctors at Shepton Mallet when using the computerised medical record. The man's condition was intimate in nature and the clinical reviewer was concerned about the availability of male healthcare staff for patients in these circumstances. Additionally, one of the key treatments for the man was out of stock for several days, as a result the clinical reviewer also raises concerns about management of stock drugs at the prison. I slightly reword and endorse these recommendations and make one additional recommendation to the Governor and Head of Healthcare concerning ensuring fuller awareness amongst staff of the process for monitoring prisoners who are at risk of self harm or suicide.

The clinical reviewer also found some examples of excellent practice, including the existence of well man checks for older prisoners, committed nursing care and excellent continuity of end of life care, which I am pleased to endorse.

This report was shared with the man's family and Shepton Mallet at the draft stage. His family had no comments to add. The services response to the recommendations is included on page 20.

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.

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SUMMARY

1. The man was 76 years old when he died in September 2011 in outside hospital of carcinomatosis and cancer of the rectum.
2. In March 1985 at the Central Criminal Court, the man was given a mandatory life sentence with a 14 year tariff. This meant that he would serve a minimum of 14 years before release on licence could be considered. Unfortunately, he did not engage with efforts to address his offending behaviour, which meant he continued to be considered as presenting a risk to the public. As a result, he remained in custody far beyond the tariff expiry date.
3. Throughout his sentence, the man spent time at various establishments, transferring to Shepton Mallet on 1 June 2005.
4. The man appeared to adopt the view that he was “unworthy” of any comforts because of his crimes. He chose to wear prison issue clothing, despite being able to wear his own clothes, kept minimal personal items and rarely asked prison staff for anything.
5. This investigation found that the man kept his symptoms to himself for a long time and by the time he did disclose them, it was too late for any effective medical intervention. That said, he was offered chemotherapy and other treatment to reduce the symptoms, but he decided not to accept them. As a result, he received palliative care and remained at the prison until his symptoms were so severe that he had to be transferred to hospital.
6. It is clear from this report that the man received good quality care while at the prison. He was well supported by prison healthcare staff and prison officers. Additionally, his care at the hospital was good, dignified and kind.
7. The clinical reviewer makes five recommendations concerning the National Screening Programme for bowel cancer, effective communication between healthcare staff and doctors, use of the early diagnosis of cancer guidelines, male staff availability for male prisoners and management of stock drugs in Shepton Mallet. All of which we slightly reword and endorse. We make an additional recommendation concerning the effective use of self-harm and suicide prevention measures at the prison.

THE INVESTIGATION PROCESS

8. After receiving notification from the prison that the man had died, the investigation into his death was opened by a member of staff from this office and a brief note made of the circumstances. The investigation was later allocated to one of my investigators.
9. On 13 October 2011, the investigator contacted the prison liaison officer and arranged for himself and the clinical reviewer to visit the prison in order to begin the investigation. The officer told the investigator that the man had had no contact with his family for a number of years
10. In the meantime, one of the Ombudsman's family liaison officers contacted the man's brother, as his next of kin, to explain the purpose of this investigation and invite the family to ask any questions or raise any issues for consideration. The family raised no issues of concern at the outset of the investigation. This report was shared with the man's family at the draft stage and they had no comments to add.
11. Somerset Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a review of the clinical care the man received while in custody.
12. On 23 November, the investigator and clinical reviewer met the prison doctor at the prison and also interviewed a nurse. Additionally, the investigator met a senior officer who had been with the man when he died, a further officer as he had known the man well and the prison Chaplain as he had acted as the prison family liaison officer. The investigator made notes of these additional interviews.
13. As well as interviewing those mentioned, the investigator met the Governor in charge of the community prison, the Chairman of the prison's Independent Monitoring Board and a senior officer representing the local Prison Officers Association. The purpose of that meeting was to explain our investigation procedure and allow them to ask questions or raise any issues.
14. After completing the interviews, the investigator met the Governor in charge of the community prison and the prison's liaison officer to feedback the findings of the investigation. As we could not be certain there were robust systems in place to ensure important medical information was communicated properly to the prison doctor, or that the doctor would routinely check previous entries, it was felt necessary to advise the Governor in charge of the community prison that the procedures needed urgent attention. The Governor said he would deal with the matter and satisfy himself that proper procedures were in place.

HMP SHEPTON MALLET

15. There has been a prison at Shepton Mallet since the seventeenth century when at that time it was known as a House of Correction. It has had a diverse history and at one stage was a military prison holding English and American prisoners. Situated close to the centre of Shepton Mallet, it is a small establishment, dedicated to holding life and other indeterminate sentenced prisoners. The prison currently holds in the region of 186 male prisoners who are mostly category C¹ in four wings.

Her Majesty's Chief Inspector of Prisons

16. Her Majesty's Chief Inspector of Prisons reports on all prison establishments. The most recent inspection of the prison was carried out 14 – 18 June 2010. In the introduction to this latest report on Shepton Mallet, the Chief Inspector said the report was positive and a testament to the benefits of having a small scale niche prison, with a settled population. Adding that despite the age of the prison, it was a safe place with positive staff prisoner relationships.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up of unpaid members of the public appointed by the Secretary of State for Justice. Their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.
18. In its latest report, covering the period from 1 April 2010 – 31 March 2011, the Board were complimentary of the work carried out by staff at the prison. They said

“Shepton Mallet continues to be a prison well served by dedicated staff, both uniformed and civilian, who noticeably go out of their way to assist prisoners and colleagues alike”.
19. The Board mentioned there are a number of prisoners who have been diagnosed as being terminally ill. They report that because the prison has no hospital wing, the prisoner has to continue to occupy his own cell and is given a personal alarm to attract attention. The Board went on to say that because the prison is over 400 years old the adaption to the needs of this category of

¹ Prisoners are placed in one of four categories according to risk: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.

prisoner is severely limited. However, they add that when adaptations are needed, they are satisfied that they are.

Compassionate Release

20. Under section 36 of the Criminal Justice Act 1991 (for those prisoners sentenced under the provisions of the Criminal Justice Act 1991) and section 248 of the Criminal Justice Act 2003 (for those prisoners sentenced under the Criminal Justice Act 2003), the Secretary of State may release a prisoner on licence at any point in the sentence if he is satisfied that this is justified by “exceptional circumstances”. Early release on compassionate grounds may be considered on the basis of a prisoner’s medical condition or as a result of tragic family circumstances. It is granted in only the most exceptional cases.
21. In reaching a decision for compassionate release on licence the Secretary of State considers the following criteria:

“The prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits on life expectancy, three months may be considered to be an appropriate period for an application to be made), or the lifer is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke.

The risk of re-offending (particularly of a sexual or violent nature) is minimal.

Further imprisonment would reduce the prisoner’s life expectancy.

There are adequate arrangements for the prisoner’s care and treatment outside prison.

Early release will bring some significant benefit to the prisoner or his/her family.”

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

Restraints and Bed-watch Arrangements

23. On each occasion a prisoner is escorted outside of the prison to hospital (either for an appointment or to be admitted as a patient) a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single handcuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Previous deaths at HMP Shepton Mallet

24. Since this office took over responsibility for investigating all deaths in prison custody in 2004, there have been eight deaths, previous to this man's, investigated at HMP Shepton Mallet. Seven were attributed to natural causes. There are no similarities in the issues arising from these previous investigations and that of this man. However it is important to note that the nursing care at Shepton Mallet has been praised on a number of occasions.

KEY EVENTS

25. For the purpose of this report we have concentrated on the period after the man arrived at HMP Shepton Mallet, 1 June 2005. However, we have included any other salient points about him.
26. Following his conviction at the Central Criminal Court in March 1985 the man was given a mandatory life sentence. The sentencing Judge set the tariff at 14 years which meant he would have to serve a minimum of 14 years before he could be considered for release on life licence. The tariff expiry date was 1 May 1999. However, before being considered for release he would have to demonstrate that his risk of reoffending had reduced and that he was no longer regarded as being a danger to the public. Unfortunately, he did very little by way of addressing his offending behaviour and so his risk of harm to the public could not be reduced, which explains why he remained in custody longer than the tariff expiry date.
27. After receiving his sentence, the man was taken into prison custody. As part of his progression through the prison system, he was transferred to other prison establishments, including HMP Channings Wood, HMP Kingston and finally Shepton Mallet.
28. Throughout his imprisonment, although entitled to wear his own clothes the man chose instead to wear prison issue clothing. Additionally, he kept minimal personal items in his cell and very rarely asked prison staff for anything. It is our understanding that the reason for him adopting this lifestyle was his continuing view that his crimes made him “unworthy” of any comforts.
29. The clinical reviewer has identified a number of dates relating to the man’s health which we feel are worthy of note. Without repeating that list we will instead highlight the more pertinent dates and symptoms. The first of those entries was 29 January 2008 when it was noted by a nurse that the man was showing signs of short term memory loss. This was noted again by the same nurse in December that year and the following month, January 2009 by a mental health nurse. The nurse made an entry into his medical record saying the memory problems did not cause any concern to the man.
30. The following year, on 28 January 2010, the man attended a routine “well man” clinic at the prison and was seen by a nurse. The nurse has recorded in the man’s medical record that there was abnormal swelling in the groin, which had been diagnosed as a hernia. The nurse also noted a small loss of weight and wrote “opens bowels every three days, occasionally irregular”. In his report, the clinical reviewer said the entry made by the nurse regarding bowel movement was ambiguous and could be interpreted in different ways. He said “It could mean that he opened his bowels every three days or so but that this varied i.e. was irregular in its timing and had been for some time; or it could mean that he usually opened his bowels every three days but this had become irregular now at times. In view of the subsequent bowel cancer diagnosis this is a key issue...” The clinical reviewer went on to say

“If the second interpretation is correct then the GP should have been sent a “task” (an electronic method of alerting the GP to important information in a patients medical notes) to decide on further action, which did not happen”.

31. In addition to the swelling, the nurse noted that the man was “low in mood” and had a loss of appetite. Because of the symptoms he was referred to see a doctor.
32. As a result of that referral, the man was seen at the prison surgery on 1 February by a doctor. Suspecting either a hernia or prostatism (swelling of the prostate gland) the doctor offered the man a rectal examination, but he declined and said he would return at a later date.
33. On 16 February, the man was seen by a mental health nurse (MHN). The nurse noted in the man’s medical record that he had severe depression and that he no longer wanted to live. The nurse referred him to a psychiatrist for counselling. In addition, the nurse noted that the room “smells” but did not elaborate on what the odour was, or what if anything was done to protect the man against any thoughts of harming himself. Additionally, the nurse noted that the man had a loss of appetite and had also lost 10lbs weight.
34. Eight days later, the man was interviewed by a psychiatrist. The clinical reviewer in his review said the psychiatrist had written the man was “depressive but odd presentation”. He was referred to be reviewed in three to four weeks. On 17 March, the man was reviewed by a mental health nurse as arranged by the psychiatrist and again on 29 July. At those reviews it was noted by the mental health nurse that the man was feeling and looking much better.
35. On 1 November, the man was again examined by a prison doctor. The clinical reviewer said the doctor wanted to carry out a rectal examination, but once again the man declined. He said the reason for advising the examination was that the man’s urinary symptoms may indicate prostate cancer.
36. As part of this investigation, the investigator met an officer who knew the man well. The officer is employed in the same wing in which the man lived. He described the man as a private person and “very selective” as to who he would speak to. The officer said the man did not work as he was retired, but that he would occasionally go to education classes. He said that, unlike the vast majority of prisoners, the man had just a few personal items in his cell. He said there was a picture of the man’s mother and a horse called “Sea Biscuit”. The only other items were a television and a number of black and white DVD films which he would watch over and over again.
37. The officer said the man was someone who did exactly the same thing every day and had routines which he very rarely varied. As an example he said he was always up early in the morning. He said the man would take exercise every day in the fresh air despite the weather conditions and would wear just

a tee-shirt, trousers and footwear, no matter what the weather conditions were. The officer said the man always walked 30 times around the exercise area after which he would return to his cell and then watch his films adding that any variance in the prison routine would upset him.

38. Asked if the man had ever discussed his health with him, the officer said no. He went on to say that the man would say he was “not worthy” and did not deserve anything other than to be in prison.
39. As part of the normal routine for preparing suitable life sentence prisoners for eventual release into the community, and subject to proper risk assessment, some prisoners are escorted by prison officers into the local shopping area to help accustom them to modern day life. On 20 May 2011, the man had been on a town visit and escorted by an officer. During that outing, he told the officer he was in discomfort and had been for some time. The officer encouraged him to see a doctor and told him that if he did not go to healthcare, then he would contact them for an appointment.
40. The man’s medical notes show that the officer contacted the prison healthcare centre the same day and told a nurse that the man was experiencing problems when passing urine. The nurse saw the man that day and took a sample of urine which was sent for analysis. The result came back the following day and was normal.
41. On 23 May, a prison doctor examined the man and carried out a rectal examination. The doctor’s preliminary diagnosis was rectal cancer and she arranged for him to be seen as an outpatient at the local hospital as an urgent patient under the “National Health Service 14 day Pathway”, (this is when urgent referrals are made and the patient seen within 14 days).
42. Ten days later, on 2 June, the man was taken to hospital where he was seen and examined. Although the clinical reviewer’s report does not say which consultant saw the man, the diagnosis made by the prison doctor was confirmed and “so advanced” that his care was to be palliative.
43. In his report, the clinical reviewer said palliative care was started that same day. He added that the nurse made an entry in the man’s medical record which said he had been shocked by the diagnosis and that he disclosed he had been in pain in his lower abdomen and pelvis for “months”. He later said the symptoms had been there for about five years.
44. Later that month, on 22 June, the man told the nurse that his symptoms were terminal and that there was no cure. The following day the prison were informed that he had two bowel cancers and that it had spread to his glands and lungs.
45. Following the diagnosis, the man was prescribed a number of pain killing medications. The clinical reviewer said the medical notes show that he had been “slow to accept stronger analgesia” but on 25 July had agreed to strong opiates in the form of a patch containing buprenorphine. (Buprenorphine is a

synthetic opiate similar to morphine but about 30 times more potent.) However, unfortunately the medication was not given to him for a further two days. The clinical reviewer said in his report "Such a delay should not have occurred and would not have happened in civilian practice".

46. As part of the palliative care, the man was being seen by a member of staff from a local hospice who was able to discuss any concerns he had and give advice. A nurse from the hospice made a note in the man's medical record which said he had refused chemotherapy and that he had the mental capacity to decline resuscitation (a 'Do Not Resuscitate Form' was completed). Additionally, the nurse said he had declined to accept a cushion to ease his pain.
47. On 25 July, an application for release on compassionate licence was completed. In a report prepared by his Offender Manager in December 2010 and forwarded to the Secretary of State as part of the application, it was noted that the man had "completed very little offence related work and often refused to engage with interventions and that his risk had not reduced".
48. A prison doctor completed the medical section of the application form and confirmed the man's life expectancy was between three and six months. In her report the doctor said

"[The man] has a terminal diagnosis of bowel cancer. He has a life expectancy of 3 – 6 months. He is currently having no chemo nor radiotherapy and his symptoms are controlled with pain relief. He is apparently mobile but has little energy and pain stops him from doing very much".
49. The clinical reviewer in his report said it was noted by a nurse that on 30 August the man had uncontrollable diarrhoea. Additionally the situation was upsetting him, and other prisoners had noticed a smell.
50. The following day, the man was examined by a prison doctor. The medical notes show a note made by the doctor which said "nasty necrotic (dead tissue) buttock plus skin infection". A further entry in the medical note made the next day by a nurse records a "fungating lesion of his buttock" (which is a type of skin lesion associated with ulceration and often a bad smell).
51. From the medical records and the clinical review the symptoms became worse and on 1 September the man was admitted into outside hospital. He was taken to hospital by ambulance and accompanied by two prison officers and monitored under the bed watch arrangements. However, due to the nature of his illness and condition he was not handcuffed.
52. As part of the normal procedure for a bed watch, a log was started. The log is used to record any significant events or observations. The log shows that the man was admitted at 11.00pm and located into a side room of the ward. Throughout the night he was restless and falling in and out of sleep.

53. The following day, a prison chaplain visited the man and assisted him to write a last will and testament. Additionally, there were visits made by prison managers and healthcare staff.
54. One of the prison chaplains told the investigator that he spoke to the man and asked him if he would like his family informed. Although he had had no contact with his family for a long time, he agreed and asked the chaplain to contact his brother, which he did.
55. In the meantime, the application for compassionate release on licence was finally completed that day and faxed to National Offender Management Service (NOMS). The reason for the delay in sending the application was because the man's Offender Manager had been on holiday and so there was a delay in obtaining some of the information needed for the application.
56. The bed watch log shows that, from 2 September, the man continued to be sleepy and occasionally he would speak with the prison staff. He was able to eat, watch television and read newspapers, but would at times become confused during conversations. The log also shows that the pain he was experiencing was increasing and so was the pain killing medication.
57. On 9 September, the man was taken to outside hospital for further examination in the surgical assessment unit because of the cancer affecting his buttock. He returned the same day for palliative care after being told his condition was not operable.
58. Three days later, 12 September, a Case Administrator from Offender Management Unit faxed a report of the man's medical condition to NOMS for inclusion with the application for release on compassionate licence. She followed up the fax later that day by telephoning NOMS to see if a decision had been made. She was informed that the man's application was being rejected as he met only two of the necessary conditions, which were suffering from a terminal illness and no longer posing a risk.
59. From then on the bed watch log shows that the man was very sleepy and did not communicate much. He was described as being settled.
60. On a day in September, a senior officer was sitting with the man. He told the investigator that when he arrived at the room where the man was it was about 7.45am. The SO said the man's breathing was heavy and loud. The SO said he had been told by a colleague who had been with the man overnight, that the man's condition had deteriorated. At about 11.52am the SO noticed that the man's breathing had stopped and so he called a nurse into the room. The nurse checked the man's condition and she asked her colleague, the Sister, to assist. The Sister carried out her own checks which showed the man had died. At 12.43pm a prison doctor arrived at the hospital to examine the man and confirmed his death.

Events following the man's death

61. Following any serious incident in prison it is normal practice to carry out a "hot de-brief". Hot de-briefs are used to obtain information about what happened as quickly as possible and while events are fresh in people's minds and to allow staff to talk about the incident. A written record is normally kept and records who was present and what individuals said and did. It is our understanding that following the man's death a hot de-brief meeting was carried out, but no record kept.
62. Shepton Mallet has a local care team to help support prison staff who may have been affected by an incident. The investigator was told that following the man's death the local care team were informed and supported staff, including the senior officer who was present with the man when he died. Additionally, a notice was issued to prisoners informing them of the death and offering support. At that time there were no prisoners who were regarded as potentially at risk of suicide or self harm. Had there been, then their individual circumstances would have been reviewed and support put in place.
63. The following day, a prison chaplain contacted the man's brother to break the news. Later that week a further prison chaplain contacted the man's family to offer them the opportunity of visiting the prison and to see the cell where their relative lived. Additionally, he offered them the man's property. It is our understanding that they declined both offers but did ask to be kept informed of the funeral arrangements and asked that his property be given to a local charity.
64. We understand the man had had no contact with his family for a very long time. The funeral was arranged and paid for by the prison and the service carried out by the prison chaplain. The man was cremated on 29 September.
65. One of the Ombudsman's family liaison officers contacted the man's family by letter, to explain the purpose of the investigation and invited them to ask any questions or raise any issues for consideration. The family have raised no issues of concern at the outset of the investigation. They will be offered an opportunity to receive and comment on the draft version of the report.
66. On 29 September, the Governor was formally told of the decision taken earlier to reject the application for the compassionate release of the man on licence. The Secretary of State had considered his application but had not been persuaded that he met the test for compassionate release at that stage.

ISSUES

Support for the man

67. Whenever a prisoner is admitted into hospital under the bed-watch arrangements it is quite normal for a manager to carry out routine visits to ensure security is being maintained correctly and deal with any issues arising. However, on this occasion it is evident from the bed watch log that a wide range of prison staff including managers, chaplains, medical staff and the prison doctors visited the man in hospital. This was a kind gesture and ensured the man's final days were not alone. It is also pleasing to note that the man, although accompanied by two prison officers for security reasons, was not restrained, which allowed him appropriate dignity in his final days.

Assessment, Care in Custody and Teamwork (ACCT)

68. On 16 February, during a meeting with a mental health nurse, the man said he no longer wanted to live. Although noting the comment in his clinical record, there is no evidence that anything further was done to protect him. We are satisfied that the man did not attempt to harm himself, but the opposite could have occurred and it is important that the proper procedures are carried out to ensure an individual is kept safe, correctly assessed and supported.

The Governor and Head of Healthcare should ensure that all staff are aware of the ACCT procedures, in particular when and how to raise concerns about potential self-harm or suicide so that at risk prisoners are effectively supported.

Clinical care

National Screening Programme for bowel cancer

69. The National Screening Programme started nationwide in the National Health Service in 2006 with everyone aged 60 – 69 being automatically invited for examination. (For those aged over 70 the programme will be available from 2014.) The clinical reviewer said the programme for bowel cancer had yet to be introduced in all prisons, although there was some piloting of the programme planned. The doctor said because the programme was not in place at Shepton Mallet, prisoners were "receiving care of a lower quality than civilians". It is important to note that the man would not have been offered screening because he was over 70 even if he had not been in prison. However, there may be other undiagnosed bowel cancer patients in prison who would clearly benefit from such screening.

The Department of Health, in partnership with the National Offender Management Service, should ensure that the National Screening Programme for bowel cancer is implemented as soon as possible in all prisons in England and Wales.

Communication between healthcare staff and doctors

70. During this investigation we were told by healthcare staff that if any abnormalities were identified during well man clinics, by nursing staff or health care assistants which required further examination by a doctor, a “task message” should be sent electronically to the doctor’s computer. The understanding by healthcare staff is that the task message would be read by the doctor when next in the prison.
71. The clinical reviewer could not be certain that task messages were routinely being sent or checked by the doctor. He felt that the entry made in the man’s medical record in January 2010 was ambiguous and should have prompted a task message.

The Head of Healthcare should develop a protocol that ensures any findings from well man clinics are sent by healthcare staff to the prison doctors in the form of a task message, which will allow the doctor to make appropriate arrangements for follow-up.

The Head of Healthcare should ensure that the prison healthcare staff are aware and familiar with the national early diagnosis of cancer guidelines issued by the National Institute for Health and Clinical Excellence and incorporate them into the previous recommendation.

Availability of male medical staff

72. We were told on a number of occasions that the gentleman was a very private man and had been given examples of where he would not allow medical examinations to take place. Whether or not his reluctance was due to the medical staff being female is not known, but what is clear is that all the nurses and the two visiting doctors are female with no provision for prisoners to be seen by a male member of clinical staff. The clinical reviewer said in general practice that situation would be “most unusual”. He went on to say that females are expected to be provided with a female doctor or nurse for intimate examinations, if they ask for it. We are concerned that the man’s condition was of an intimate nature and he may have benefited from the option to be seen by a male member of healthcare staff.

The Head of Healthcare should review the availability of male healthcare staff for the prisoners to consult, particularly regarding matters of an intimate nature.

Availability of drugs for prisoners with palliative care needs

73. The prison healthcare does not receive daily pharmacy supplies or routinely keep strong opiate drugs as a stock item. We were told that buprenorphine patches are a common prescription at the prison, but were not held in stock. As mentioned previously, once the man had been prescribed the patches it

was a further two days before the prescription was completed, which is unacceptable.

The Head of Healthcare should review the range of stock drugs held for prisoners with palliative care needs, particularly long acting opiates, to ensure that there is no significant delay in treatment.

Good practice

74. In general practice well man clinics are not routinely offered to the public. At Shepton Mallet prisoners over the age of 70 are offered a well man check every six months and it is their decision whether they accept the offer or not. In this man's case he had regular checks and missed just one in the summer of 2010.
75. The clinical reviewer commented on examples of "excellent practice" relating to committed nursing care and continuity of end of life care.

CONCLUSION

76. In his clinical review summary the doctor said the healthcare provided to the man was generally of a good standard and comparable to that provided in the community. He adds that the existence of well man checks for elderly prisoners, committed nursing care and end of life practitioner care are excellent examples of excellent practice.
77. The clinical reviewer said the man would have had symptoms for many months before finally being forced to disclose them. He adds that the late diagnosis of cancer was due to the man making a decision not to reveal his symptoms, some of which were externally visible, but hidden by him under clothing. He said the man had been given information about bowel cancer during a well man session in December 2010, but sadly he decided not to seek medical assistance.
78. We are satisfied that had the man decided to share his symptoms earlier with medical staff, although the outcome might have been the same, his quality of life could have been improved. The medical care and support from prison staff was of a high standard, appropriate and dignified.
79. Although there are six recommendations resulting from this investigation there is nothing to suggest the man's care was not of an appropriate standard. His view was that he did not deserve anything and probably explains his decision to keep his symptoms to himself, until a stage when they could no longer be hidden.

RECOMMENDATIONS (Service response is shown in italics)

1. The Governor and Head of Healthcare should ensure that all staff are aware of the ACCT procedures, in particular when and how to raise concerns about potential self-harm or suicide so that at risk prisoners are effectively supported.
***Accepted:** Head of Communities to discuss with Head of Residence and Safer Custody locally the need for any comment or concern raised by a prisoner regarding intention to self-harm or commit suicide to be recorded and risk assessed formally through the ACCT process. Regardless of individual perceptions of likelihood and feasibility, and to ensure that any local policies reflect this. Head of Communities to publish a notice to staff regarding this, whilst also recognising the excellent and decent work that staff took in supporting the man at the end of his life. Head of Communities to endeavour to embed the formalising through ACCT process is embedded through the management team and well as through the healthcare department.*
2. The Department of Health in partnership with the National Offender Management Service should ensure that the National Screening Programme for bowel cancer is implemented as soon as possible in all prisons in England and Wales.
***Not Accepted:** Programme was being rolled out within nationally agreed timescales. Supporting evidence provided by service to this effect.*
3. The Head of Healthcare should develop a protocol that ensures any findings from well man clinics are sent by healthcare staff to the prison doctors in the form of a task message, which will allow the doctor to make appropriate arrangements for follow-up.
***Accepted:** This does already occur but does need to be tightened up and evidenced through a formal protocol.*
4. The Head of Healthcare should ensure that the prison healthcare staff are aware and familiar with the national early diagnosis of cancer guidelines issued by the National Institute for Health and Clinical Excellence and incorporate them into the previous recommendation.
***Accepted:** This will be included in a formal protocol as above*
5. The Head of Healthcare should review the availability of male healthcare staff for the prisoners to consult, particularly regarding matters of an intimate nature.
***Not Accepted:** The recruitment process for all prison healthcare staff is through Somerset Partnership's recruitment team. The process is fair and robust. The sex of all candidates is hidden until after the selection process for interview has been completed. Service users have not raised the lack of male staff within the prison healthcare team as an issue. There is access to male locum General Practitioners if necessary. This has not therefore been considered as a 'genuine operational requirement'. The patient was a very private person and it is considered he would have declined consent to an intimate examination by any member of the medical profession.*

6. The Head of Healthcare should review the range of stock drugs held for prisoners with palliative care needs, particularly long acting opiates, to ensure that there is no significant delay in treatment.

Not Accepted: *Already in place, over and above what is available in the community. As part of the response to this recommendation Healthcare at Shepton Mallet provided evidence of stocks available at the time of the man's death.*