PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Whatton in March 2012

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Whatton. The man died from malignant skin cancer which had spread to other organs of his body. I offer my condolences to his family and all those affected by his death.

The investigation was carried out by one of my investigators. A clinical reviewer conducted a review of the man's clinical care. HMP Whatton cooperated fully with the investigation.

The man had been in prison since 2009. He had been in remission from cancer for five years and was considered to be in satisfactory health when he transferred into Whatton in March 2010. On 25 March 2011, he reported a lump in his left groin which was diagnosed a month later as metastatic malignant melanoma for which he had surgery. In January 2012, he was further diagnosed with cancer in both eyes and, soon after, was told that his cancer was terminal. The man did not apply for temporary or compassionate release as he wanted to remain at Whatton for palliative care.

The investigation found three areas for improvement regarding more comprehensive documentation of cancer care reviews, the need to appropriately justify the use of restraints when escorting very sick prisoners and the need for sensitive communication of a prisoner's death to those staff and prisoners who knew him well. However, overall, I am satisfied that the prison provided a very good standard of care for the man and respected his wishes to remain on his wing for as long as possible. A named nurse ensured he was well looked after and sensitively involved his family towards the end of his life. All those involved in his care at the prison are to be commended for their compassionate approach which allowed the man to die with dignity.

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 **November 2012**

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SUMMARY

1. The man was convicted on 29 October 2009 and sentenced to four years in prison, with a further period of three years to be served on an extended licence in the community.

2. The man transferred to HMP Whatton from HMP Lincoln on 3 March 2010. He received a first reception health screen from a nurse who noted his raised blood pressure but otherwise reported him as being fit and well. During this health screen, the man disclosed that he had been in remission for the past five years from malignant neoplasm and malignant melanoma (both are types of cancer). The nurse referred him to the general practitioner (GP) clinic at Whatton and the man's medical notes from his home GP were requested.

3. On 17 November 2010, the man reported to a nurse that he had found a patch of dry skin, in the same place where he had skin cancer six years earlier. The GP at Whatton examined him a few days later and, because of his history, referred him to a specialist under the referral procedures for suspected cancer. He was seen by a specialist dermatologist on 9 December and provided with a cream to treat dry skin conditions.

4. On 25 March 2011, the man reported a swollen gland in his groin. The prison doctor made a further referral for suspected cancer and it was subsequently confirmed that the man had cancer of the lymph node. On 13 January 2012, he was seen by the optometrist at Whatton after reporting severe headaches and blurred vision. After examining him, the optometrist immediately referred him to the on-call ophthalmologist (a specialist in eye diseases). Two weeks later, it was confirmed that he had cancer in both eyes and that the prognosis for his life expectancy was weeks or months.

5. The man's clinical record states that he understood and accepted this and he wanted to remain at Whatton for palliative care. Healthcare staff facilitated his palliative treatment and provided appropriate aids and accommodation to assist his comfort. They also arranged for his family to visit him and kept them informed of his condition. The man's health deteriorated rapidly and he died on in March 2012. His family were notified promptly and funeral expenses were offered.

6. Although the man had regular and good quality cancer care, the frequency and level of reviews were initially unclear. We have therefore recommended that the reviews are better documented. We are also concerned that, although the man was assessed as low risk, restraints were used when he was escorted to hospital appointments. The prisoner who assisted the man with his daily personal care found out about his death in a regrettable manner. We have made a recommendation about breaking the news of a prisoner's death and offering support to key individuals. Nevertheless, the investigation has found that the care given

to the man was both timely and appropriate, and at least the equivalent of that expected in the community.

THE INVESTIGATION PROCESS

7. The investigator and a colleague visited Whatton on 20 March 2012 and obtained relevant records from the prison's liaison officer. They met representatives from the Prison Officers' Association and the Independent Monitoring Board, as well as the nurse responsible for end of life care. The investigator and his colleague visited the man's cell and the palliative care suite where the man died. In advance of the visit, notices were issued announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward as a result.

8. The investigator returned to Whatton on 2 May 2012 and interviewed three members of staff and one prisoner. He also met the head of performance, and gave preliminary feedback on the findings of the investigation.

9. A clinical reviewer was commissioned to review the man's clinical care on their behalf. He was provided with all relevant documentation to assist his review.

10. The investigation report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers spoke to the man's sister on 10 April to let her know about the investigation and to allow his family to contribute. His sister commended the staff at Whatton and the care given to the man and said it was "better than he would have received in the outside community". She gave particular praise to the nurses, chaplains and liaison staff and noted that a memorial service held at Whatton for her brother was excellent.

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

HMP WHATTON

13. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 prisoners. All the prisoners are sex offenders.

14. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Community Health Trust. The healthcare centre is open daily from 8.00am to 7.30pm, with a local out of hours service providing cover at night. Specialist clinics are provided for older prisoners and those with life long conditions. There are no inpatient beds at Whatton.

15. HM Inspectorate of Prisons (HMIP) last inspected Whatton in January and February 2012. The prison was found to be a safe and decent prison. Health services were judged to be generally good with staff who were polite and responsive to prisoners' needs. Primary care was well organised and access to nurse-led, GP and dental services was good. There was a wide range of chronic disease clinics and enablement therapies to meet the needs of the population. Medication administration was found to be compromised by the lack of appropriate supervision of some medication. Palliative care arrangements were described as particularly good.

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and humanely. In its most recent report, for the period June 2010 to May 2011, the IMB at Whatton reported favourably on the healthcare provided and noted that during the year a new palliative care suite known as The Retreat, had been opened, funded by a King's Fund Grant. This provided a specialist room in the healthcare unit for terminally ill prisoners.

17. We have investigated a number of deaths at Whatton. There have been six deaths since January 2011 of which the man's death was the fifth. Like the man, many of them had significant long-term medical conditions. Our reports into the first two of these deaths reflected well on Whatton. The investigation into the death of the third man found that his chronic diseases were managed well at the prison, but there were occasions when staff on his residential unit did not respond appropriately to his ill health. There are no similar concerns in this investigation.

ISSUES

Background

18. On 29 October 2009, the man was convicted and sentenced to four years imprisonment, with a further three years to be served on an extended licence period in the community. He went to HMP Lincoln on the same day. On arrival, he had an initial health screen at which it was noted that he was fit and well. The man had no previous convictions.

19. The man transferred to HMP Whatton on 3 March 2010. A nurse in reception carried out an initial health screen and noted that the man had been diagnosed with high blood pressure for which he was being treated but he was otherwise reported as being healthy. The man disclosed that he had been in remission from skin cancer for the past five years after having an operation to remove a malignant melanoma (a form of skin cancer).

20. After examining the man on 17 March 2010, prison Dr A at Whatton, requested the details of his medical history from his community GP. The notes show that the man had a malignant melanoma surgically removed in February 2005, and a further operation in January 2007 to remove a squamous carcinoma (also a form of skin cancer). They also showed that, in January 2009, he had been seen in the dermatology clinic in Lincoln hospital. During this routine appointment, it was reported that he was well and that there were no signs of the recurrence of either tumour.

21. In view of the man's history of cancer, Dr A referred him to a specialist. On 4 May 2010, a reply to this was received from the administration manager at Queen's Medical Centre Nottingham. The letter informed the doctor that they were unable to treat the man as he had been clear of cancer for five years and he did not need to be seen as there had been no further issues.

22. Two days later, on 6 May 2010, a further letter was received from a doctor at the Queen's Medical Centre in which he wrote that the man's melanoma was over five years before and he could therefore be discharged from follow up. The doctor added, "If he were to develop any new lesions however I think they should be viewed with a very high index of suspicion and we would be happy to see him if needed".

The diagnosis of the man's terminal illness

23. On 17 November 2010, the man showed the practice nurse at Whatton a patch of dry skin in an area where he had previously been treated for skin cancer. The nurse made an appointment for the man to be seen a week later and told him to contact the healthcare department in the meantime if there was any change to the affected area.

24. Dr A examined the man on 24 November 2010. He referred him the same day, under the two-week rule, to the dermatology clinic at Queen's Medical

Centre. (This refers to the aim of NHS patients with suspected cancer to see a specialist within two weeks of a GP referral.) The man was seen by a hospital specialist at the Queen's Medical Centre on 9 December 2010. The medical records at Whatton show that he returned from this appointment with two tubes of Dobovet cream (to treat dry skin conditions).

25. On 25 March 2011, Nurse A, a practice nurse at Whatton, examined the man as he had a swollen lymph gland in his groin. Dr A followed up Nurse A's examination on 30 March 2011 and made a further referral to the Queen's Medical Centre.

26. On 24 April, Nurse A noted in the medical record that the man had been told that he had lymph node cancer and he wanted more information. The record does not make it clear when this diagnosis was made. The nurse informed the man that an appointment had been made for him to see Nurse B, a senior practice nurse who specialises in cancer and end of life care at Whatton, the following week. Part of Nurse B's role is to ensure that patients have the same opportunities and choices about their end of life care as they would in the community.

27. A week later, on 1 May, Nurse B saw the man and they discussed his recent diagnosis, which had been confirmed as metastatic malignant melanoma (the spread of cancer from one organ to another). The nurse noted that at the time of that meeting the man seemed very positive. At this stage, he was awaiting a CT scan along with surgery to remove the lump in his groin. He was subsequently treated at hospital.

28. On 11 January 2012, the man informed Nurse C that he was suffering from a headache, blurred vision, flickering to his left eye, and dizziness to the point of collapse. On examining him, the nurse noted that his left eye appeared bloodshot and that his speech was slurred. The man was referred to Dr A the same day. The following day, the doctor referred him to the ophthalmic services at the Queen's Medical Centre, noting on the referral that the man had a history of cancer.

29. The man was examined by the optometrist at Whatton on 13 January, who found "a large grey patch" in the temporal aspect of the retina. The man described this as "like looking through a net curtain". The optometrist concluded that it could be either a detachment of the retina or related to the man's melanoma. The man was taken the same day to the A&E department to see an on-call ophthalmologist. An entry in the medical record on 30 January, confirmed that the man had cancer in the back of both eyes.

30. We conclude that, when the man reported his symptoms to healthcare staff, he was reviewed promptly by the prison GP. Patients with symptoms of suspected cancer must been seen by a specialist within two weeks of being referred by a GP. The Clinical reviewer gained the impression that on one occasion there was a delay as the referral letter was not despatched until six days after the GP's request. However, evidence

gathered by the investigator shows that the referral was made on the same day as the GP consultation, which was on 30 March.

Informing the man about his condition and treatment

31. The man was mindful of his personal skin cancer history and was concerned with any new lesions. Healthcare staff were responsive and acted promptly when he reported symptoms. The medical records confirm that he was told of his diagnoses, although the exact dates and times were not recorded. The man was able to discuss his diagnoses with prison healthcare staff.

32. An undated letter from a consultant plastic surgeon at Queens Medical Centre Nottingham, informed the healthcare department at Whatton that the man had metastatic melanoma. The consultant plastic surgeon arranged a groin dissection which was carried out on 21 May 2011.

33. On 17 February 2012, a consultant oncologist from Nottingham University Hospital, wrote to the healthcare department at Whatton to advise that the man had multiple cerebral metastases and bilateral chorodial metastases (eye cancer.) He noted that the man had been referred to him for a course of palliative radiotherapy and that a course of chemotherapy would be considered if his condition improved. Nurse B kept the man informed of changes to his condition.

34. After a hospital admission at the end of January 2012, the man was made aware that his condition was terminal and he told his family in mid-February. On 27 February, the man discussed with Dr A, Nurse B and his family his wish to sign a 'do not resuscitate' form. This gave him the opportunity to note formally his wish not to be revived, or given advanced life support, if he suffered from a cardiac or respiratory arrest. On 1 March, after further consultation with healthcare staff and prison officers, his wish not to be resuscitated was noted on the clinical record and the appropriate agencies informed.

35. We are satisfied that the man was informed fully and promptly about his condition and given information on the treatment options and the progression of his illness in a considerate and timely manner.

The man's medical appointments and treatment

36. The man attended all his appointments for secondary care and was occasionally admitted to hospital as an inpatient. An endoscopy appointment was cancelled but this was due to him being ill on arrival at the hospital. That appointment was subsequently re-arranged.

37. On 23 May 2011, the man attended City Edward Hospital for surgery on his groin. A drain was subsequently fitted and the man was discharged back to Whatton. On 27 May, Dr A reported that the man had leakage from the drain and he had to be re-admitted to hospital for further surgery to correct

this.

38. On 17 June, Nurse C noted that the pump on the man's drain was not functioning correctly and arranged a replacement. Both the drain and the wound required daily examination and it was necessary to change the man's dressings daily. This was carried out and well documented in medical records.

39. After the man's return from hospital appointments, the specified nursing requirements were met, including wound care and medication changes. The man experienced some complications with a drain that he had had fitted post-surgery. However, this was managed effectively by the nursing staff who identified problems with the drain and arranging for a replacement from the hospital.

40. The prison doctor had open discussions with the man about his life expectancy. As a result of this, the man chose not to attend his last two radiotherapy appointments.

41. The clinical reviewer considers that liaison between the prison and outside hospitals was very good at all levels. Following diagnosis, and throughout the emergency and planned admissions to hospital, healthcare staff liaised with hospital staff by telephone to ensure timeliness on every occasion. Hospital discharge summaries and out-patient clinic letters confirmed diagnoses and advised on action plans. The clinical reviewer confirms that the management of the man's care in prison was equivalent to that he would have expected to receive in the community.

42. Much of the man's treatment was prescribed by external specialists and subsequently administered in the prison. He had a named nurse to coordinate his care and treatment. All actions were appropriately documented in the medical records and it is clear that staff were thorough in following up treatments. The clinical reviewer judges that the man's assessed healthcare needs were met and we agree.

The man's pain relief and medication

43. The man's pain relief was initially managed with simple analgesia. When he was diagnosed with cancer the pain was managed with both short and longer acting morphine which he kept in his cell. Initially, he did not take it all but took increasing doses as his illness progressed. When he was no longer able to swallow, he was given injectable rather than oral morphine. On one occasion in February 2012, following an admission to hospital, through no fault of prison staff, no discharge letter nor medication, such as morphine, was provided. Prison healthcare staff were aware of this and the hospital sent it shortly afterwards by taxi.

44. Due to problems with his eyesight, Nurse B gave the man a dosette (a box used for organising medication) to assist him in taking medication.

45. On 6 March 2012, the day before the man died he moved to The Retreat, and a syringe driver (a small, lightweight, battery powered pump which administers pain relief under the skin) was supplied to allow him to give himself medication as and when he needed it. The Liverpool Care Pathway, discussed later in this report, was also put into place at this time. (This programme is used to apply the model of hospice care for the dying into other healthcare settings, using an integrated care pathway for the last hours of life.)

46. On occasion, the man's medical records showed extended periods between cancer care reviews. The investigator discussed this with Nurse B and although it is apparent that the man received the correct level of care and was seen more frequently it was not always annotated on the man's medical records. We therefore make the following recommendation.

The Head of Healthcare should ensure that all cancer care reviews are correctly annotated on patients' medical records.

47. We are satisfied that the man's pain relief was well managed. He was given pain relief as required and healthcare staff were responsive to his needs, changing the method of administering medication as his condition changed.

Liaison with the man's family

48. On 7 February 2012, a special visit was arranged for the man with some members of his family in The Retreat to provide a quiet and dignified environment at a difficult time. The prison's family liaison officer, his offender supervisor and Nurse B also attended.

49. After the visit and following a discussion with Nurse B on 9 February, the man decided to inform his family that his condition was terminal. He was worried that his family would have to pay funeral costs, but Nurse B reassured him that the costs would be met by the prison. The next day, the man gave his consent for staff to share information with his family.

50. Due to the circumstances of his offence, the man had had limited contact with his family after his imprisonment. Nurse B therefore asked him to compile a list of family members it would be appropriate for her to contact as his condition worsened. On 21 February, Nurse B telephoned the man's sister and introduced herself as the man's key worker. They discussed his condition and his outstanding medical appointments.

51. The man met Dr B to discuss his prognosis, on 27 February. At this meeting, the doctor told him that he had only weeks or months to live, which the man understood and accepted. He stated his wish not to be resuscitated in the event of a cardiac or respiratory arrest. At his request, Nurse B discussed this with his family before he made his decision.

52. On 6 March, the man's condition had deteriorated to such an extent that the decision was taken to move him from his wing to The Retreat. Nurse B contacted the man's sister to give her an update on his condition. The following day, the nurse informed the man's sister that his condition had deteriorated further and that a syringe driver to alleviate his pain was being used and the Liverpool Care Pathway was now in place. The nurse advised the man's sister that owing to his decline, his family might wish to bring forward a visit they had planned for 9 March. His sister informed the nurse that this was not possible but if his condition deteriorated further during the night she wished to be informed. She would then pass on this information to the rest of the family.

53. At 6.20pm on the day the man died, Nurse B noticed that the man had stopped breathing and verified that he was dead at 7.11pm. She telephoned Dr A, to confirm the death. The nurse also rang the man's sister to inform her of his death, as previously agreed, and to offer her support.

54. Governor A acted as the family liaison officer. She telephoned the man's sister the following day to offer support and also broke the news to his son. She spoke to his family on a number of occasions afterwards.

55. Whatton met the funeral expenses in accordance with Prison Service guidelines and invited the man's family to a memorial service. This was held at Whatton on 15 March and the man's funeral took place two weeks later on 29 March.

56. The man was estranged from his family during the earlier part of his sentence. The investigation found that when he became terminally ill, staff contacted them and facilitated a visit. Afterwards, with the man's consent, Nurse B updated his family on his condition and offered to bring forward a subsequent planned visit when it was clear that his death was imminent. His sister was informed of his death promptly and other family members were later contacted. Although this was not done face-to-face, we are satisfied that there was prior agreement to the news being conveyed by telephone.

The man's location

57. When the man's illness was diagnosed, he lived on C2 wing. His wanted to stay on this wing as long as possible to enable him to be near to his support network and other prisoners. Prisoner A assisted the man with his everyday needs, which enabled the man to remain on the wing for as long as possible.

58. On 4 February, hospital staff advised that the man should be located in a shared cell due to ongoing risks. Neither the man nor healthcare staff considered this appropriate and they made every effort to enable him to stay in the cell of his choice. In his clinical review, the clinical reviewer agreed that this was the correct decision.

59. On 6 February, the man agreed to move to C1 landing. This allowed him to have a toilet in his cell and still remain close to his support network. The following day, a wheelchair was provided. He was later given a high back chair, as he was experiencing discomfort sitting, and other aids such as a more comfortable mattress, pillows and a walking frame.

60. To ensure that the man was able to stay in his preferred location as long as possible, while meeting his increasing medical needs, Nurse B felt that it would be beneficial for him to have a hospital bed in his cell. In order to facilitate this, the door to the shower room was removed and replaced with a shower curtain. A hospital bed was supplied on 27 February.

61. A full and comprehensive occupational therapy assessment was carried out on 1 March 2012 and further equipment was provided to help alleviate the man's discomfort.

62. As the man became more bedridden, he agreed to move to another unit and, on 4 March, he moved to A8. A8 was described by Nurse B as, "a bigger room which is used to facilitate and support patients who require end of life care".

63. On 6 March, the man moved to The Retreat. A private ambulance was arranged to make the short journey as comfortable as possible. The man died the next day

64. Throughout his illness, the man expressed a wish to remain at Whatton and this was facilitated by the staff at the prison. We are pleased to note that he was accommodated according to his wishes and good efforts were made to provide appropriate aids and adaptations to meet his needs.

Compassionate release

65. 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 only granted in exceptional circumstances. The decision to release a prisoner on compassionate grounds is made by the Secretary of State. Release on temporary licence (ROTL) can be granted by the Governor. When diagnosed with terminal cancer, the man decided that he did not want to apply for compassionate release or ROTL. He made it clear that he did not want to go to a hospital or a hospice, but wanted to stay at Whatton.

66. On 27 February, Dr B had a frank conversation with the man about his prognosis and life expectancy. The man said he understood and accepted his prognosis. He reiterated that he wished his care to be at Whatton and not in a hospital or hospice.

67. The man also discussed the possibility of release on licence with his offender supervisor with whom he had formed a close relationship. The man's offender supervisor said that the man said:

> "I would rather be in here and get the treatment I need than be in a hospice where I would be forgotten. I want to be surrounded by the people I know, the other prisoners on the wing and I want to be here"

68. It was very clear that the man wished to die in prison and his wishes were followed.

Palliative care plans

69. On 6 February 2012, Nurse A initiated the Gold Standard Framework for cancer care (The Gold Standard Framework is a systematic approach to optimising the care for patients nearing the end of their life in any setting). She spoke at length to the man and ensured that he fully understood the progressive nature of his cancer. She noted that the man remained positive despite his advancing illness.

70. The man then spoke to Dr B and requested the full facts of his cancer and informed the doctor that he was still to decide whether or not to have chemotherapy.

71. When a patient with a terminal illness reaches the final stages of their life, healthcare staff at Whatton use a care plan to ensure that everything possible is done for the patient in accordance with their wishes. The Liverpool Care Pathway for the Care of the Dying, a nationally recognised plan, was implemented on 7 March. Entries on the man's medical record, in the last few hours of his life, indicate that the pathway was followed and that medication was given in accordance with the agreement.

72. The man's medical records show that there was clear and consistent communication between prison healthcare staff and those at the outside hospital. We are satisfied that timely palliative care was put in place and staff were responsive to the man's needs in accordance with the agreed care plan.

Restraints, security and bed watch

73. The man attended a number of external hospital appointments, on some occasions as an inpatient. Any prisoner required to remain in hospital, who has not been released on temporary licence, is escorted by prison officers. The escort documents show that during those periods, officers used standard handcuffs for journeys and an escort chain while he remained in hospital. (An escort chain is a single handcuff is attached to the prisoner and a length of chain connects this to another worn by an officer.) The restraints were removed when the man had treatment.

74. Risk assessments for these external escorts were carried out and included input from healthcare staff. The level of risk was assessed against risk to the public, risk of hostage taking, escape potential, likelihood of outside assistance, risk to females and risk to hospital staff. In all these areas the risk was assessed as low. Despite this, the man was subject to restraint by an escort chain. As justification for the strength and composition of the escorts, it was annotated "due to nature of offence". As the man was judged to be low risk against all the assessed criteria we do not consider that the use of restraints was justified. Two escorting officers should have been sufficient for security purposes, and it was unnecessary to subject a dying man to the indignity of having to attend hospital chained to an officer. The last occasion restraints were used was eight days before the man's death when he was very seriously ill. We therefore make the following recommendation.

The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.

Notification of the man's death

75. During the man's illness, a fellow prisoner, prisoner A had been asked to assist him with everyday tasks, such as washing and dressing. This enabled the man to remain on the wing where he wanted to be as long as possible. During this time a prisoner and the man formed a close relationship. However, the prisoner was not told personally about the man's death and became aware of it when he was asked to put up a general notice to notify prisoners of the death. This was insensitive. An officer subsequently asked whether the man's death had affected prisoner A and advised him to take time off from his duties that day if he wished.

76. Similarly the man's offender supervisor had also spent a considerable amount of time with the man throughout his illness and before his death. He had also attended the meeting with the man's relatives at the man's request. The man regarded his offending supervisor as a source of support through an extremely difficult time. However, like the prisoner, the offending supervisor was not personally informed of the man's death. He first became aware of it when he heard radio transmissions in relation to a death and assumed the message related to the man. A governor telephoned him the following day to offer support.

77. While it would have been desirable for the man's offending supervisor to have been informed personally, it was an unfortunate chance that he heard the news over the radio before he was contacted personally. We consider that someone should have prioritised notifying prisoner A and offered some support. We make the following recommendation.

The Governor should ensure that following a death in custody, prisoners and staff who are known to have close personal relationships with the prisoner, are informed of the death personally and offered support.

CONCLUSION

78. Before his arrival at Whatton, the man had been in remission from cancer for five years. The diagnosis that his cancer had returned was made in a timely manner and, as his condition progressed, the care given to him by prison healthcare staff was of a high standard, at least equivalent to that available in the community. The man's medical records show that the level of liaison between healthcare staff and the secondary care providers was of an acceptable standard. We do not consider the use of restraints to attend hospital appointments was always justified by the prison's own risk assessment.

79. Every effort was made by Whatton to facilitate the man's wishes to remain on the wing as long as possible, and to remain at the prison for his final days. We are satisfied that the progression from the wing to The Retreat was appropriate and that the man's views were taken into consideration at every stage.

80. We are pleased to note the good quality of care and treatment facilitated by Nurse B. In addition to her work with the man, she ensured that his family were kept informed as his illness progressed and that they were able to visit him before he died.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all cancer care reviews are correctly annotated on patients' medical records.

   Accepted. "The Head of Healthcare has made all healthcare staff aware that contemporaneous reporting is a mandatory requirement with health records. In this instance, "Cancer care review" is a specific read code within the electronic record system that identifies specific intervention (review of progress in relation to the Gold Standard Framework) by the End of Life Lead Nurse. No other staff use this code. Gaps will be apparent within the record as the patient may be stable, treatment may have finished and there is not a requirement for an intervention such as this. All patients have an open appointment and can be seen by the End of Life Lead Nurse as and when required."

2. The Governor should ensure that following a death in custody, prisoners and staff who are known to have close personal relationships with the prisoner, are informed of the death personally and offered support.

   Accepted. "A review of the current contingency plan has taken place following a desktop exercise. This will now be included in the amended version."

3. The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.

   Accepted. "As stated in the report the level of risk was assessed against risk to the public, risk of hostage taking, escape potential, likelihood of outside assistance, risk to females and risk to hospital staff. It appears that in this case the restraints could have been removed for some of the hospitalisation period. However it is not always clear due to medical in confidence issues if these risks can be mitigated in full. A daily visit is carried out by a senior manager to the hospital. Part of this visit checks the use of restraints. Senior managers will be instructed to fully document reasons for the continued use of restraints in such a circumstance. The risk assessment will be amended to relay this information to oncoming staff. Bedwatch staff will also be instructed to make the Duty Governor aware if circumstances change in relation to a prisoner's condition, where restraints should be removed to give appropriate levels of decency and enable hospital staff to carry out treatment. The same applies where restraints should be re-applied where a prisoner's condition improves. These instructions will be included in the establishment LSS and prisoner escort packs."