PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the of a man at Addenbrooke's Hospital, in May 2012, while in the custody of HMP/YOI Littlehey

Report by the Prisons and Probation Ombudsman for England and Wales

December 2012

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This is the report of an investigation into the death of a prisoner at HMP Littlehey. The man died from progressive brain damage caused by Acquired Immunodeficiency Syndrome (AIDS), in Addenbrooke's Hospital, Cambridgeshire, in May 2012. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical review was carried out into the medical care the man received in prison.

The man was admitted to hospital on 14 March, suffering from headaches and other symptoms when he was diagnosed with Human Immunodeficiency Virus (HIV). He died in hospital just over two months later. It does not appear that his HIV diagnosis could reasonably been made much earlier, but some opportunities for follow-up appointments and onward referral were missed before he was admitted to hospital. A prison family liaison officer was appointed at an early stage and, although not well documented, it is apparent that commendable efforts were made to keep in contact with and support his family. The prison waited too long before considering the possibility of compassionate release and sadly the man died before an application could be progressed.

I am particularly concerned that the prison should have considered it necessary to use restraints for a month after the man was taken to hospital, even though his health was very poor and deteriorating. The Prison Service has a responsibility to balance the needs of security with the duty to treat prisoners with humanity and to maintain their dignity and privacy. In the man's case, it does not seem that this balance was achieved. The risk assessments were not reviewed regularly and in sufficient depth, and requests by hospital staff to reduce the degree of security were not properly considered. Eventually, for the last few weeks of his life, restraints were removed which allowed the man to die with some 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 **December 2012**

CONTENTS

Summary

The investigation process

HMP Littlehey

Issues

Conclusion

Recommendations

SUMMARY

1. The man was remanded to prison in June 2007 and sentenced to nine years imprisonment the following January. A deportation order was later served as he had entered the UK illegally. After spending time at other prisons, he moved to Littlehey in January 2009.

2. Over the next three years, the man was assessed by a number of different prison doctors for minor conditions, such as coughs, headaches and lesions on his scalp. In January 2012, a blood test revealed an abnormally low white blood cell count which was not appropriately followed up.

3. The man was losing his sight and becoming increasingly confused around this time. On 22 February, he was assessed by an optician who found nothing physically wrong with his eye. No onward referral or appointment for review was given despite the deterioration in his eyesight. The clinical reviewer concluded that the man should have been referred to an ophthalmic consultant at that stage. However, this would have taken a number of weeks so did not delay the man's ultimate diagnosis.

4. On 14 March, the man complained of severe pain behind his eyes and was quickly admitted to hospital. The following day he was diagnosed as HIV positive. He did not respond to treatment and was given palliative care until he died from a rare brain disorder most likely caused by AIDS.

5. For the first month the man was at the hospital, he remained escorted by two officers and handcuffed to one of them. We consider this level of security was unnecessary for a prisoner who was assessed as a low risk of escape, terminally ill and deteriorating daily. The on-going decision to use restraints was not fully justified by a thorough and regularly reviewed individual risk assessment. On 13 April, it was agreed that only one officer needed to remain with the man and restraints were removed. By this stage, he was paralysed and blind down one side and could not walk. The prison was unable to provide the investigator with the escort logs relating to three of the weeks that the man was in hospital as they could not find them.

6. The process for the man to be released on compassionate grounds was started on 17 May, after his sister requested, on 9 May, that the man be moved to a London hospital. The man died two days later. Although we recognise the difficult circumstances involved, this application could have started earlier.

7. The prison appointed a family liaison officer to liaise with the man's family on 16 March. A log was not started at the time as is best practice. Both family liaison officers had a high commitment to their role and made considerable and commendable efforts to engage with his family, but we consider the prison should have considered contacting the man's sister at an earlier stage. There was some delay in informing the man's wife of his death but we accept that this was acceptable in the circumstances.

THE INVESTIGATION PROCESS

8. This office was notified of the man's death on 20 May 2012. The investigator visited Littlehey on 29 May. She met the Governor, a Prison Officers' Association representative, the Chair of the Independent Monitoring Board (IMB). The man had not made any applications to the IMB.

9. During the visit, the investigator interviewed the clinical services manager and the family liaison officer (FLO) who had been in contact with the man's family, SO A. She also collected documents relating to the man.

10. The investigator issued notices inviting staff and prisoners to contact her with any relevant information. She later interviewed a prisoner who responded.

11. A clinical reviewer was, commissioned to carry out a clinical review of the healthcare the man received. The clinical reviewer and the investigator conducted joint interviews with staff at Littlehey on 3 July. The clinical reviewer completed his review on 17 August.

12. Her Majesty's Coroner for Cambridgeshire was notified of the investigation and will receive a copy of this report to assist with his enquiries.

13. One of our family liaison officers (FLO) spoke to the man's family to explain the investigation process and learn of any questions or concerns they wished to be considered. His sister was concerned that the prison had not told her about the man's declining health sooner. She said by the time she was informed, the man was unable to recognise or have a conversation with her. Following the issue of the draft copy of this final report the only issue the man's sister raised was regarding the number of times she had visited her brother in hospital.

14. 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/YOI LITTLEHEY

15. HMP Littlehey is a category C male prison outside the village of Perry in Cambridgeshire. (Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape.) It holds a maximum of 1.220 with up to 480 young adults accommodated in a new young offender unit opened early in 2010.

16. Health services at Littlehey are commissioned by NHS Cambridgeshire. Medacs Healthcare Group provides locum GPs at the prison six days a week. On-site specialist services include dentistry, optometry, podiatry and physiotherapy. Nurse-led clinics are held for life-long conditions such as asthma and diabetes. There are no inpatient beds at Littlehey.

Her Majesty's Inspectorate of Prisons (HMIP)

17. The most recent HMIP report was an unannounced full follow up inspection conducted in November 2011. Inspectors commented that healthcare services were generally good, but considered the healthcare department was too reliant on locum doctors. Inspectors noted that, "The medical provider, Medacs, used a high number of locum staff, which resulted in inconsistency in prescribing and decision-making" and sometimes there was no medical cover at all. The inspectorate also repeated a previous recommendation to reduce the waiting time to see the optician but noted good partnership working with NHS Cambridgeshire supported by prison management.

Independent Monitoring Board (IMB)

18. All prisons have an IMB made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In its latest report for the year from February 2011 to January 2012, the IMB commented that:

> "The Board believes that the Healthcare department generally offers a caring environment for the prisoners within HMP Littlehey. Medical services offered within the prison are supplied by the local Primary Care Trust (PCT). The provision of GP services by Medacs continues to cause concern, particularly with the supply of temporary cover. The prison is working with the PCT to remedy this inconsistent medical service".

Previous deaths at Littlehey

19. This office has previously investigated 18 deaths at Littlehey. None of the circumstances of those deaths are similar to the man's.

ISSUES

Background

20. The man was born in West Africa. He moved to France at the age of three and entered the UK illegally. He had been in prison a number of times before his most recent sentence.

21. On 21 January 2008, at Inner London Crown Court, the man was sentenced to nine years imprisonment for an offence, which he had committed in 2002. He had been in prison on remand since 27 June 2007. The sentencing judge recommended the man was deported at the end of his sentence and he was later served with deportation order.

22. The man initially spent time in HMP Brixton and HMP Pentonville. He transferred to HMP Blundeston on 24 July 2008 and then to Littlehey on 12 January 2009, where he remained until admitted to hospital in March 2012.

The diagnosis of the man's terminal illness

23. The man saw a number of different GPs at Littlehey over three years for a variety of symptoms including headaches, nausea, lesions and coughs. The clinical reviewer writes:

> "Between August 2008 and January 2012 the man was seen infrequently complaining of occasional headaches, occasional constipation and persistent itching and flaking of the scalp. Mild painkillers were given for his headaches and various anti-fungal lotions and shampoos were given for the scalp lesions. There is no evidence that these problems became progressively worse from the medical records, and they seemed to respond to the treatment.

24. On 31 March 2011, the man saw the dentist who found his understanding of his planned treatment was poor. Six months later, on 21 September 2011, he saw the dentist again because he had bleeding gums. The dentist treated him for tooth decay and a gum infection.

25. Over the next three months, the man reported itching and flaking of the scalp several times and received moisturisers and anti-infective shampoos. The clinical reviewer also highlighted:

> "On 31 Jan 2012, blood samples were taken to test his thyroid gland, liver function and to check his blood count and blood sugar. There is no record indicating why these tests were done. The blood count was reported to show low numbers of white blood cells (both neutrophils and lymphocytes) but no other abnormality. A visual inspection of the blood film reported some unusual sticking together of some of the white cells and the consultant haematologist stated in the report that the neutrophil count might be an underestimate because of this. The report was filed as normal by the prison GP. The low white cell counts

were noted by the same doctor who stated that the man needed to speak to a doctor about the results. There is no record of this taking place or of the man being informed of the low white blood counts."

26. A prisoner on the same landing as the man, said that he realised the man was losing his sight and hearing in January 2012. The man asked him for help when dialling telephone numbers, as he could not see the digits on the keypad. The prisoner also told the investigator that the man had difficulty finding his own cell and he complained of headaches.

27. An optician assessed the man on 22 February 2012. The man told the optician he had been experiencing reduced distance and near vision for two weeks. When tested, he could not read the largest letters on the wall chart. The optician told the investigator that the man had seemed confused, for example he could not tell him which wing he lived on. Following further examination of the eye, the optician concluded that there was nothing physically wrong with his eye and reported his findings to Nurse A.

28. The optician told the man to make another appointment if his vision deteriorated further or if he was concerned. The optician told the clinical reviewer that he was sure the man had understood this. The optician did not have any further contact with the man.

29. In relation to the optician's assessment, the clinical reviewer concludes:

> "The man's quite rapid onset of loss of vision was extremely well examined by the visiting optician with no optical cause for it being found. However, in view of the inability to come to a diagnosis, it would have been prudent to refer the patient to an Ophthalmic Consultant. This would not have been an emergency referral with such gradual onset of visual deterioration so if he had been referred it is unlikely that the man would have been seen by the ophthalmologists in a hospital setting before his emergency admission to Addenbrooke's Hospital. "

30. The investigator was concerned that the high turnover of GPs provided by Medacs might have affected the care the man received and the timeliness of his diagnosis. The Clinical Services Manager at Littlehey, estimated over 35 different GPs had worked at the prison in the year up to May 2012. He told the investigator that when he reviewed the man's notes after his death, he considered that the symptoms could have been indicators that he was HIV positive. He believed the number of different GPs who worked at the prison sometimes compromised prisoners' continuity of care.

31. The Healthcare Manager told the investigator that he had raised the difficulties caused by the high number of different GPs working at the prison with both the commissioner of services and the Governor of Littlehey. However, he told the investigator:

> "I think he [the man] was seen for a number of different things … none of which seemed to present as a flashing light to say that there is

> something particularly wrong. And his presentation, which caused him to be transferred to secondary care, kind of came out of the blue. I know that the optician had some concerns when he saw him. But looking at the notes I think on balance there were a number of different things that wouldn't necessarily leap out."

32. The clinical reviewer also believes that the number of different GPs who dealt with the man did not impact on the speed with which he was diagnosed as being HIV positive. He did not consider the man's symptoms were indicative of the virus. Nevertheless, it is clearly unsatisfactory to have such a high turnover of GPs at the prison which must impact on continuity of care. This problem has been indentified by the Inspectorate of Prisons and the Independent Monitoring Board. We understand the prison is trying to address the situation so no further recommendation is made.

33. Senior Officer (SO) B, who worked on the wing where the man lived at Littlehey, said that shortly before he went to hospital the man got easily confused and sometimes did not know his own cell. He also complained of headaches to the senior officer.

34. Before the man's admission to hospital, he had no identified serious medical problems. On 12 March 2012, a nurse was called to see him on the wing, as he had headaches and dizziness. His balance, walking, muscle strength and speech did not show any gross abnormality and he was given ibuprofen (a simple painkiller) for his headache.

35. Two days later, on 14 March 2012, the man complained of severe headaches and pain behind his eyes. He was said to be crying with pain. A doctor arranged for him to be taken to Hinchingbrooke Hospital Accident and Emergency Department. The following day he transferred to Addenbrooke's Hospital in Cambridge, suffering from confusion and deteriorating vision. A magnetic resonance imaging scan showed that the man had progressive multifocal leukoencephalopathy (PML), a disorder which damages the material that covers and protects nerves in the brain. It can be caused by viruses, including the AIDs virus.

36. Prisoners at Littlehey are not routinely tested for HIV although they can request a test. The clinical reviewer states:

> "Even with hindsight, the multiple presentations to prison GP staff with headaches and a dry scalp condition are not in themselves strong triggers to suspect or investigate this diagnosis. The only opportunity to make an earlier diagnosis, seen in this investigation, was the low white blood cell count on the specimen of 31 January 2012. I would expect the GP at HMP Littlehey to have followed this up within a few days of the original result. Should the possible significance of this result not have been understood by the GP he should have contacted the laboratory for advice. The recorded action for the patient to be seen by a doctor to discuss this was never followed up. However, the

incidence of HIV in adult males from West Africa is less than 2 in 100 giving his GPs a very low index of suspicion."

37. The clinical reviewer concluded that there was no reasonable opportunity to make an earlier diagnosis and that the level of primary medical care in prison was at least equal to that expected in the wider community. He also told the investigator that there was no reason why the man should have been referred to secondary care because of his symptoms such as skin lesions as these were minor. We accept this conclusion, but note that opportunities were missed to refer the man to specialists following abnormal blood tests and deterioration in vision. We therefore recommend:

The Head of Healthcare should ensure there is full and timely scrutiny of investigation results, adequate follow up and onward referral of abnormal results and timely discussions of all results with prisoners.

Informing the man about his condition and treatment

38. The man was in hospital when he was diagnosed as being HIV positive. He started anti-HIV therapy on 15 March. Hospital staff discussed his diagnosis and treatment with him on 21 March.

The man's medical appointments and treatment

39. After his diagnosis, the man remained in hospital. He had no further medical appointments at the prison and his treatment was the responsibility of the hospital. His condition gradually worsened over the next two months and he died on 19 May. The cause of death was PML. He was also suffering from cerebral toxoplasmosis (a parasitic infection in the tissues and cells of the body). No post mortem was carried out.

The man's pain relief and medication

40. The hospital staff were responsible for ensuring that the man suffered as little pain as possible following his diagnosis. Before his admission, he was given appropriate pain relief and medication in relation to his symptoms such as headaches and lesions.

Liaison with the man's family

41. SO C was appointed as the prison's family liaison officer (FLO) on 16 March and asked to contact his next of kin, after hospital staff told the prison that the man was not responding to treatment and he was now only being given palliative relief. The SO did not begin a log of events at that time as he believed this was only necessary when a prisoner's death was imminent or had occurred. The SO telephoned the man's wife but did not get through. As he was not due at work for the following few days, he emailed the duty governors over the weekend to inform them.

42. On 17 March, the duty governor spoke to the man's wife and told her of his condition. She also gave the hospital the man's wife's telephone number so that they could give her more details about his condition. The senior resident doctor spoke to the man's wife that day and asked her to contact the prison about visits arrangements. She never contacted the prison.

43. SO C spoke to the man's wife the next week when he returned from work. The SO realised that she had learning difficulties and found it difficult to understand the information he was giving her. He tried to explain that the man was seriously ill and encouraged her to visit him. He asked if there was anyone who could take her to the hospital and she gave him the details of her social worker. The SO then telephoned the social worker who told him that the man had a sister but the SO felt unable to contact her as she had not been listed as one of the man's next of kin.

44. The hospital contacted the man's wife on 16 April and 18 April to update her regarding her husband's deteriorating condition.

45. SO C arranged for the man's wife to visit her husband on 27 April. The visit was then rearranged for 1 May, at her social worker's request, but the man's wife did not turn up to meet her social worker. We are satisfied that the SO made substantial efforts to engage with the man's wife and encourage her to visit her husband, even arranging a visit on his day off. Unfortunately as a log was not kept, it has been difficult to piece together much of this information. On 3 May, the deputy governor, B, emailed SO C and asked him to ensure that he was keeping a detailed record of his contact with the man's family, but this was not done.

46. The same day, the hospital told SO C that the man would not be given any further treatment. The man's sister had now contacted the prison and the SO telephoned her and arranged for her to visit the man the following day, again on his day off. He picked her up from the station and accompanied her to the hospital at his own expense. The SO also gave the man's sister his personal mobile number so that she could contact him any time. We consider that SO C commitment to his role as FLO was commendable. The man's sister visited her brother a further seven times before he died. During the last of these visits she was accompanied by his two children.

47. From 13 May, SO C was due to complete a week of night shifts, followed by three weeks of annual leave. The prison did not appoint another FLO before he left although SO C had requested this.

48. A manager at the prison met the man's sister at the hospital on 17 May. She informed her of his prognosis and that they would start the process for the man to be released on compassionate grounds.

49. SO A, was immediately, assigned as a new FLO following the man's death. The hospital told the man's sister of his death shortly afterwards. The SO telephoned the man's sister the next day and discussed how to break the news to his wife. They agreed that the news would be best given by his wife's social

worker, as his wife distrusted people she did not know. The SO had to wait until the next day, 21 May, to telephone her social worker as she worked Monday to Friday. The social worker agreed that she should break the news of the man's death to his wife, and told her later that day at her home. The SO subsequently spoke to the man's wife who gave permission for the man's sister to act as his next of kin. While there was an unfortunate delay until the man's wife was told of his death, we are satisfied that in the circumstances this was justified and the result of a sensitively made and considered judgement.

50. On 22 May, SO A took the man's sister to the hospital. The man's sister agreed that his property should be returned to his wife. A memorial service was held at the prison for prisoners and staff. The man's family did not wish to attend or visit the prison. The prison paid to repatriate the man's body to Nigeria.

51. PSI 64/2011 indicates that when a prisoner is seriously or terminally ill a FLO must be appointed and it is good practice for a log of the contact with the family to be maintained. The PSI says that following a death in custody a log book recording contact must be opened as soon as a FLO is deployed. In the man's case, a log was not started until after he died, over two months after the governor was appointed as FLO. Both the FLOs said that when trained a number of years before, they were told that the log should be started at the time of death. They were unaware of the current guidance that it is best practice to start a log once family contact is started. We consider a log should have been started at an early stage to provide a record of contact for the FLO and for other prison staff or agencies.

52. The man's sister was upset not to have been told about the man's condition until 3 May and it is not clear how she was informed of the man's illness. When she visited her brother the following day, she said he was unable to recognise or respond to her. Prison Rule 22 requires that if a prisoner becomes seriously ill "the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

53. SO C informed the man's wife who was his nominated next of kin, but unfortunately the man's sister's contact details were not in his prison record. There is no indication that the man asked that she should be informed, possibly because he was too ill at that stage. Although the SO had been told in March by the man's wife's social worker that he had a sister he felt unable to contact the man's sister until she contacted the prison herself on 3 May. While he then made every effort to assist her in visiting her brother we consider that further consideration should have been given to contacting the man's sister at an earlier stage. In view of the uncertainty and complexity of the family situation, we understand the difficulty for the SO, but this does not appear to have been discussed with a senior manager. Again the absence of a family liaison log makes it difficult to establish what happened or what was considered.

The Governor should ensure that a family liaison log is started as soon as a family liaison officer is deployed and that unless there is good reason not to do so all significant family members are contacted.

The man's location

54. The man moved from Littlehey to Hinchingbrooke Hospital on 14 March, and then to Addenbrooke's hospital in Cambridge on 15 March, where he remained until he died. On 9 May, his sister asked whether it would be possible for the man to transfer to a London hospital, which would have made it easier for her and his wife to visit him. While Addenbrooke's was an appropriate location to treat the man, we agree it would have been preferable if possible for him to transfer to a hospital nearer his family. This became part of the consideration of his compassionate release and unfortunately no decision was able to be made before the man died ten days later.

Compassionate release

55. The operational manager said the deputy governor had asked him to consider the possibility of the man's release on temporary licence (ROTL) in the week beginning 9 April. If successful, the man would no longer have been escorted by officers at the hospital. As the man was subject to a deportation order, they first consulted the United Kingdom Border Agency (UKBA). On 25 April, the Governor and the operational manager agreed that ROTL was inappropriate due to the seriousness of the man's offences. The operational manager explained that even if the man had been subject to ROTL, he would still have kept an officer at his bedside in plain clothing to provide support for the man and his family as well as a link with the prison.

56. Unlike ROTL, where the decision is made by the Governor, the decision to grant early release on compassionate grounds is made by the Secretary of State, taking into account information provided by the prison and medical opinion. Guidance in Prison Service Order (PSO) 6000 advises that 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.

57. Early release can be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits but three months is considered to be an appropriate period. A clear medical opinion on a prisoner's likely life expectancy is required. The Secretary of State also has to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family.

58. On 9 May, the man's sister asked SO C whether her brother could be transferred to a London hospital so that he could be nearer to both her and his wife. SO C emailed the deputy governor, B, the healthcare manager and the clinical services manager to arrange a meeting to consider this request. The

next day, Duty Governor B asked the Head of the Offender Management Unit, to consider whether the man met the criteria for compassionate release. The Head of the Offender Management Unit replied on 14 May and on 17 May, duty Governor B asked the operational manager and Head of the Offender Management Unit to produce an application for the man's compassionate release as soon as possible.

59. One of the managers at the prison, the clinical services manager, the operational manager and the healthcare manager met the ward nurse in charge of the man's care later that day, along with his clinical nurse specialist. The nurse said that in her experience of patients at the same stage of the condition the man had three to four weeks left to live. The nurse said that he was deteriorating daily, no longer on medication or treatment and unable to eat or drink. The most the man was capable of was moving his left leg. The man's sister was also at the hospital and the prison staff informed her that as the man's life expectancy was less than three months they would start the process for compassionate release.

60. On 18 May, the operational manager emailed duty Governor B indicating that they should progress the request for compassionate release. He had spoken to UKBA and they had asked to be kept informed. The operational manager said that as they had not been given a definite prognosis for the man until 17 May, he considered that the time taken to start processing the man's release on compassionate grounds was reasonable. The medical section of the application form was completed by a prison doctor and forwarded to the Governor. This stated:

> "Incapable of most daily activities due to fatigue, malaise and having entered terminal stage. Currently bed bound … Recently acute confusion, neutropenic, intercranial abcess".

61. Sadly, the man died in the hospital, before the prison submitted his application for release on compassionate grounds.

62. Although the hospital gave no definite prognosis about life expectancy until 17 May, there is no evidence that prison staff requested information before this or gave any consideration to the possibility of compassionate release until The man's sister made an enquiry on 9 May, about the possibility of a move. It then took a week after that for the application process to be started.

63. The healthcare manager said that the man deteriorated quickly after he was admitted to hospital and the prison were kept informed of his condition. He added that, "It was quite a confusing clinical picture really in terms of what the actual diagnosis was." However, prison staff were aware that he was only being given palliative relief from 16 March and had not been responding to treatment since that time. On 3 May, the escort officers recorded that he was "seriously ill and not anticipated to have long left".

64. The Head of Healthcare said that Addenbrooke's gave regular updates on the man's condition and that Littlehey clinical staff contacted their counterparts at

the hospital regularly. They were told two days after his admission that he was on palliative treatment only and unresponsive to treatment and they deduced from the type of blood tests, the nature of his condition. We consider that prison staff should have actively sought information from the hospital and started the procedures for compassionate release sooner. We make the following recommendation:

The Governor and Head of Healthcare should ensure that early release on compassionate grounds is actively considered whenever a prisoner's condition is diagnosed as terminal and that applications are completed urgently.

Palliative care plans

65. The man's treatment and palliative care were managed entirely at the hospital.

Restraints, security and bed watch

66. When prisoners are taken to hospital, a risk assessment should be completed which considers the risk posed to the public by the prisoner, their potential for escape and the likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used, if they are needed. The risk assessment should effectively balance security needs with the health and dignity of the prisoner, and be reviewed by prison managers each day that a prisoner is in hospital and amended as necessary. The assessment should include medical opinion about how the prisoner's condition impacts on his risk.

67. The man's risk assessment, completed on 14 March, and authorised by the operational manager, indicated two officers would accompany the man, and he would be handcuffed to one of them. The operational manager told the investigator that this was the standard risk assessment for a category C prisoner and would be the same for all category C prisoners, unless there were exceptional circumstances. No other reasons are recorded for the man being subject to this level of security escort other than "category C".

68. The man's risk of harm to the public was assessed as medium,and his risk of escape was recorded as low. There is no reference to his medical condition and whether and how this impacted on his risk. There appeared to be an unsatisfactory reliance on his security category rather than an individual assessment taking account of all relevant information. The Governor told the investigator that the man was a serious sex offender facing deportation. He was concerned that the man presented a risk to the public and that his family might have tried to take him home, particularly in light of his wife's learning difficulties. There is little to support this view. His wife never visited him at the hospital and these factors do not accord with the information on the risk assessment form where prison staff had recorded his escape potential as low.

69. The operational manager said that SOs reviewed this risk assessment at the hospital daily and a governor reviewed it weekly. The only evidence the

investigator found of this was on the front sheet on each daily log where there is a space for management checks. It is not possible to determine from most of the entries whether this check was completed by an SO or a governor. In any event, the check simply requests the person completing it to confirm the escort is in possession of the risk assessment, rather than a considered review of the risk assessment.

70. On 15 March, the operational manager and the clinical services manager visited the man to assess the level of escort required. The services manager told the investigator that the man could not see the drink in front of him. Nevertheless, he remained handcuffed to an officer. The following day, the prison was told he was being given palliative care only and was not responding to treatment. There was still no review of his risk.

71. On 23 March, the nurse manager called the hospital and spoke to a nurse. There had been little improvement in the man's condition, his eyesight was poor and he had fallen twice since admission. The nurse was concerned that the escort officers by his bedside were preventing him from getting the complete rest he needed. The nurse manager spoke to a governor about the nurse's concerns. Three days later, the nurse at the hospital remained "extremely concerned" that the officers were still at the man's bedside.

72. The operational manager told the investigator that he was aware nursing staff at the hospital had concerns about the officers' presence and one of his SOs went to the hospital to explain the arrangements. We consider that it was entirely appropriate for the hospital staff to raise concerns if they believed that the security arrangements were impacting on the man's health and treatment. The British Medical Association (BMA) guidance is that:

> "prisoners are entitled to the same standards of health care as the rest of society. This includes respect for the patient's dignity and privacy. Outside prisons, there should be a presumption that prisoners are examined and treated without restraints, and without prison officers present, unless there is a high risk of escape or the prisoner represents a threat to him or herself, the health team or others."

There is no indication that prison staff re-considered the escort arrangements as a result of the nurse's concerns or that the risk assessment was reviewed.

73. On 13 April, the duty doctor at the hospital asked for permission to remove the escort chain from the man as his condition was deteriorating and his likelihood of escape was very low. An escort risk assessment review was completed later that day. This concluded that the man's escort should be reduced to one officer and the cuffs removed. The assessment notes:

> "The man is currently paralysed down one side and blind one side. He is not capable of any walking movement. Recommend reducing to one officer and no cuffs for the short term – to review on Friday 20th and daily by senior officer".

74. The operational manager said that this assessment took place on the basis of discussions with healthcare staff and by personally visiting the man at the hospital. He thought this reduction in restraint was made at the appropriate time as the man's likelihood of recovery had been unclear before this. On 17 April, this risk assessment was checked and remained the same.

75. On 24 April, the clinical services manager and the operational manager visited the man. The nurse at the hospital told them that the man had further deteriorated. It was agreed that an officer escort was no longer required. However, an officer stayed at the hospital with the man. The Governor explained that this was to provide the man and his family with support and to give the hospital a direct link to the prison.

76. In June 2010, a concordat was agreed between the National Offender Management Service and the National Health Service. The concordat makes clear that the medical condition of the prisoner should be considered as part of a risk assessment. The levels of restraint used must be proportionate to the "perceived security risks" and balanced by considerations of care and decency. The concordat says:

> "Using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts unless justified by security consideration",

77. We accept that the Prison Service has a duty to protect the public. However, there is also a responsibility to balance the need to hold prisoners securely with the duty to treat them with humanity and to maintain their dignity and privacy. .

78. The man remained handcuffed to an officer until 13 April, nearly a month after his admission to hospital. By this stage, he was paralysed and blind down one side and incapable of walking. In the interim, hospital staff had registered their concerns at the level of escort. It is our opinion that the decision to remove the restraints could have been made sooner. The risk assessments should have been reviewed more regularly as the man's condition deteriorated. Throughout his time in hospital the man was described as "polite", "courteous" and "compliant". We consider that Littlehey took too long to review the man's escort arrangements and make the following recommendation:

The Governor should ensure that comprehensive, individual security risk assessments are completed for prisoners admitted to hospital which take into account the prisoner's health and mobility. Assessments should be reviewed regularly by a senior manager to reflect any changes in circumstances and whenever a health professional raises concerns.

79. Despite the investigator's requests to the security department, deputy governor and the liaison officer, the escort logs for the periods 15 March to 23 March and 19 April to 2 May were not provided. The prison said they could not be found. These are important records and their absence means it has not been possible for us to comment on the security arrangements during that period, or other

aspects of the man's treatment during that time. We therefore make the following recommendation:

The Governor should ensure that escort officers' logs are completed and retained for the entire period a prisoner remains subject to escort in hospital.

CONCLUSION

80. Although the man reported minor ailments throughout his time in prison, he had no known serious medical conditions until his admission to hospital two months before his death. On two occasions in prison opportunities to arrange follow-up care or onward referral were missed. However, the clinical reviewer concludes that this did not impact on the timeliness of the man's eventual diagnosis. Once the seriousness of his condition became apparent, he was promptly taken to hospital.

81. The man remained in hospital care until he died. We do not consider that use of restraints was properly justified by individual regularly reviewed risk assessments. The man's condition was known to be terminal for some time but the prison was too slow to begin consideration of compassionate release. There was some commendably active family liaison but contact was not recorded until after the man's death. However, overall the prison appears to have dealt with the man and his family sensitively and appropriately.

RECOMMENDATIONS

1. The Head of Healthcare should ensure there is full and timely scrutiny of investigation results, adequate follow up and onward referral of abnormal results and timely discussions of all results with prisoners.

   HMP/YOI Littlehey has accepted this recommendation. All biochemistry/haematology results are sent directly to SystmOne electronically for review by an appropriate clinician. An audit process is in place to ensure this is done correctly.

2. The Governor should ensure that a family liaison log is started as soon as a family liaison officer is deployed and that unless there is good reason not to do so all significant family members are contacted.

   HMP/YOI Littlehey has accepted this recommendation. Family liaison officers have been reminded that their FLO log must be opened as soon as they are appointed to a case and unless there are good reasons not to do so all significant family members are contacted.

3. The Governor and Head of Healthcare should ensure that early release on compassionate grounds is actively considered whenever a prisoner's condition is diagnosed as terminal and that applications are completed urgently.

   HMP/YOI Littlehey has accepted this recommendation. The Head of Healthcare will notify the Governor as soon as a prisoner's condition is diagnosed as terminal. An application for release on compassionate grounds will be then considered and processed when deemed necessary as a matter of urgency.

4. The Governor should ensure that comprehensive, individual security risk assessments are completed for prisoners admitted to hospital which take into account the prisoner's health and mobility. Assessments should be reviewed regularly by a senior manager to reflect any changes in circumstances and whenever a health professional raises concerns.

   HMP/YOI Littlehey has accepted this recommendation. The security risk assessment form will be updated to include an individual health assessment. This assessment will include the mobility of the individual and take account of health professional concerns.

5. The Governor should ensure that escort officers' logs are completed and retained for the entire period a prisoner remains subject to escort in hospital.

   HMP/YOI Littlehey has accepted this recommendation. All escort logs and risk assessment will be retained for the duration of the escort / bed watch. Escorting staff will be reminded to ensure that the logs are to be completed comprehensively.