PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in May 2012 at HMP Whatton

Report by the Prisons and Probation Ombudsman for England and Wales

January 2014

This is the report of an investigation into the death of a man at HMP Whatton on 26 May 2012. The man was 66 years old and died from lung cancer. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical review of the man's healthcare was undertaken by a clinical reviewer. HMP Whatton cooperated fully with the investigation. I apologise for the delay in issuing the report.

The man first reported symptoms towards the end of 2011 and, after several tests, he was diagnosed with lung cancer in April 2012. By then, the disease was terminal and only palliative care was given. The possibility of compassionate release does not appear to have been considered and the man remained at Whatton until he died in the prison's palliative care suite.

Whatton made prompt and appropriate referrals to diagnose the man's condition. Healthcare and prison staff provided a high standard of compassionate care, which took full account of the man's wishes. The prison was also very supportive to his family. We conclude that the man's care at Whatton was at least comparable to that he could have expected to receive in the community. However, as in other cases at Whatton, restraints were used when the man visited hospital, which were not appropriately justified by a risk assessment.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man had no serious medical conditions when he was sentenced to prison in 2008. He complained of a pain in his shoulder on 7 November 2011, for which he was prescribed analgesics. The pain persisted but a chest X-ray showed no abnormalities. By mid-January 2012, he had developed central chest pain. Two weeks later, the prison doctor referred him to Nottingham Cancer Care Centre under the fast track procedures for suspected cancer.

2. A further X-ray and hospital examination revealed nothing abnormal, but the doctor at Whatton still suspected that the man had cancer. On 7 March, she found further indicative symptoms and made a second cancer referral. A week later, the man was admitted to hospital, where he was provisionally diagnosed with lung cancer which was confirmed by biopsy results in April. The man was told the illness was terminal. An oncologist retrospectively discovered that lesions were visible on X-rays that had previously been considered clear.

3. The man did not wish to have active treatment for his cancer, or to be resuscitated in the event of a cardiopulmonary arrest. His treatment was palliative only. Healthcare and prison staff supported him throughout his illness. They also facilitated his reconciliation with estranged members of his family and provided them with appropriate support. The man was fully involved in decisions about his care, but the possibility of early release on compassionate grounds does not appear to have been discussed with him.

4. As he became more incapacitated, the man moved from his residential wing into a specialist cell equipped with a hospital bed and other appropriate facilities. He remained there until it was evident he was in the last stages of his life and at 4.30pm on 25 May, he moved to Whatton's palliative care suite for prisoners at the end of their lives.

5. The man's night carer reported his death at just after 11.00pm that night. The out of hours duty doctor would not attend the prison to certify death, so an ambulance was called and paramedics formally declared his death at 12.28am on 26 May.

6. Our investigation found that the prison appropriately referred the man for clinical investigations after he reported his symptoms. His condition was not diagnosed until the prison doctor made a second referral. Although the secondary care service did not meet the two-week target to see the man after the first cancer referral, the clinical reviewer considered that the short delay did not impact on the eventual outcome.

7. We are satisfied that staff at Whatton provided a high level of support and care for the man, comparable to that he could have expected in the community. However, during hospital appointments and admissions, he was subject to the use of restraints in spite of risk assessments indicating he was a low risk of escape and harm to others.

THE INVESTIGATION PROCESS

8. Notices announcing the investigation were issued to staff and prisoners, inviting anyone who might have information relating to the man's death to contact the investigator. There was no response.

9. The investigator visited HMP Whatton on 6 June 2012. An operational manager gave him a full briefing about the circumstances surrounding the man's death and he visited parts of the prison, including the palliative care suite, known as the Retreat, where the man died. He met the Vice Chair of the Independent Monitoring Board and a representative of the local Prison Officers' Association.

10. On 31 July, the investigator returned to the prison and formally interviewed three members of prison staff. He also spoke informally to a member of the healthcare staff to clarify issues raised by the clinical reviewer.

11. One of the Ombudsman's family liaison team spoke to a member of the man's family, to tell her about the investigation and to offer the opportunity to raise matters that she wished the investigation to consider. She had no concerns about the care the man received in prison but wanted background information about the diagnosis of his illness and subsequent treatment.

12. The investigator obtained copies of the man's prison and medical records. Nottinghamshire NHS Trust commissioned a doctor to conduct a clinical review of the care the man received at Whatton.

13. We informed HM Coroner about the investigation and a copy of this report has been sent to him.

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.

15. The man's family received a copy of the draft report and indicated that their questions had been answered.

16. We are sorry for the delay in issuing this report which was due to workload pressures and a backlog of cases that we are striving to clear.

HMP WHATTON

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

18. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Healthcare Foundation 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. Prisoners with terminal illnesses are able to spend their last days in a purpose-built palliative care suite funded by the King's Fund, known as The Retreat.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) last inspected Whatton during January and February 2012, four months before the man's death. The prison was found to be safe and decent. 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 excellent.

Independent Monitoring Board

20. 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 2011 to May 2012, the IMB at Whatton reported favourably on health services at the prison. They were satisfied that the clinical needs of prisoners were met and noted that there was a high quality of care for prisoners with terminal illness in a new palliative care suite.

Previous deaths at Whatton

21. We have investigated a number of deaths at Whatton. The man was the sixth prisoner to die there since January 2011. Like the man, many of the other prisoners had serious long-term medical conditions. We repeat a recommendation made in recent reports about the use of restraints without proper justification.

ISSUES

The diagnosis of the man's terminal illness

22. The man was remanded into custody at HMP Nottingham on 11 July 2008. This was his first time in prison. He had no physical health conditions apart from an arthritic knee and wrist. On 21 October 2008, the man was convicted of sexual offences and sentenced to ten years' imprisonment. On 5 November 2008, the prison doctor noted in the man's medical record that he had been a moderate smoker for most of his life. Staff gave him smoking cessation advice and with their support, he attempted to stop.

23. The man transferred to HMP Whatton on 20 March 2009. A year later, on 10 March 2010, he started a ten week course of patches and support to reduce his use of tobacco. He completed the course on 12 May, but continued to smoke thereafter. From his reception into prison until 7 November 2011, the man had only minor ailments.

24. The man reported a pain in his shoulder at the beginning of November 2011. He thought he had injured it while working in the prison gardens. The doctor prescribed pain killers and advised him to contact healthcare staff if the symptoms persisted. He did so and was seen by a doctor on 25 November, who requested a chest X-ray. This took place on 6 December, and was reported as being normal the next day.

25. By 16 January 2012, the man had developed other symptoms, including central chest pain and the sensation of a 'fur ball stuck in his chest'. A doctor noted some weight loss and, during a subsequent review on 30 January, she referred him under the two-week rule to the Nottingham Cancer Care Centre. (The two-week rule is a target for NHS patients with suspected cancer to see a specialist within two weeks of a GP referral.) An endoscopy (an internal examination using a tube fitted with a camera) was arranged for 27 February, to look into his stomach, which was outside the two-week target. In the meantime, on 14 February, the man was admitted to hospital as an emergency with breathing problems and severe pain behind the sternum. This was diagnosed as a chest infection and he returned to Whatton.

26. The prison doctor reviewed the man on 17 February, as she was still concerned that he might have cancer in his upper stomach. However, the endoscopy on 27 February did not indicate this. At a further review on 7 March, a doctor found enlarged lymph nodes under both arms and, after requesting more blood tests, made a second two-week cancer referral. On 15 March, before an appointment was received, the man was admitted to hospital as an emergency because of the deterioration in his condition. He returned to prison two days later with a provisional diagnosis of lung cancer. Biopsy results received on 13 April confirmed this diagnosis.

27. After the diagnosis of lung cancer, the oncologist at the hospital reviewed the X-rays taken in December 2011 and February 2012, and concluded that with hindsight, both showed signs of a lesion. It is likely that the shoulder pain first

reported on 7 November 2011 was caused by the lung cancer, but healthcare staff at Whatton could not have known this and nor was it picked up by the subsequent X-rays.

28. Although he was not seen by a hospital specialist within the 14-day target for suspected cancer referrals on 30 January, the clinical reviewer commented that, “Any small delay here was clinically unimportant and would have made no impact on the ultimately fatal outcome.” This does not fall within our remit, but the clinical reviewer has made a recommendation to the NHS. The clinical reviewer concludes that, following the onset of symptoms, healthcare staff at Whatton made timely referrals to secondary care and we agree.

Informing the man about his condition

29. On 19 March 2012, two days after his return from hospital the doctor spent 40 minutes talking to the man in his cell about the likely diagnosis. Whatton received the biopsy results on 13 April and the palliative care lead nurse confirmed to the man that he had lung cancer. The doctor discussed the cancer diagnosis with him on 16 April and told him that it was terminal.

30. After several discussions with the prison doctor, it was noted in the man’s clinical record on 23 April that he was adamant that he did not want to be resuscitated in the event that his heart or breathing stopped. He signed a disclaimer to this effect on 25 April, witnessed by the palliative care lead nurse. Healthcare staff also notified relevant prison staff and sent a fax to Nottingham Emergency Medical Services (NEMS), the out of hours emergency service and East Midlands Ambulance Service. The man also commented that he was unsure whether he wanted any active treatment at all for his cancer.

31. We are satisfied that the man was appropriately informed about his illness.

The man’s medical appointments and treatment

32. The man attended the oncology clinic for a review on 25 April. The oncologist wrote to Whatton on 26 April (received on 8 May), to say that "the man presents with incurable non small cell lung cancer and has been referred for consideration of systemic treatment." The oncologist also suggests, "in the first instance that we try to repeat the lymph node biopsy" and depending on the result and if his condition deteriorates "we may have to concentrate on best supportive care".

33. On 30 April, the doctor left a message for the oncologist requesting information as to the options for a healthcare plan of care and noted in his SystmOne record, "Is he going to be fit for any treatment if continues like this". The doctor spoke to the clinic on 1 May who told her that he was borderline for treatment and they intended to repeat a biopsy to see if chemotherapy was possible. Although they considered that if the man deteriorated further, there would be no benefit to be gained from either the biopsy or treatment. On 4

May, a doctor noted that he thought the man was unfit for any further treatment, such as chemotherapy.

34. The man attended all but two hospital appointments. The prison cancelled an appointment arranged by the hospital endoscopist for 20 March 2012, as the hospital had not informed healthcare staff at Whatton in time. An appointment due on 25 May 2012, was cancelled with the man's consent because of his frailty. No emergency hospital admissions were delayed and, generally, communications between the prison and hospitals were good.

The man's pain relief and medication

35. When the man first reported shoulder pain on 7 November 2011, it was initially managed with paracetamol and ibuprofen. After the diagnosis of a chest infection on 14 February 2012, he was treated with antibiotics. By 19 March, his pain levels had increased and he was prescribed short and longer acting doses of morphine which he was allowed to keep in his cell and controlled the pain well. The man did not take all the prescribed morphine during the early part of his illness but in the later stages as his pain worsened, the dosage was increased. After the cancer was found to be terminal, his pain relief was altered to oxycodone to reduce the side effects of the morphine. When the man became unable to swallow properly, this was changed to injectable morphine and a hyoscine patch was used to alleviate its side effects, nausea and vomiting.

36. The man was admitted to the Retreat on the afternoon of 25 May. A syringe driver (an electronic device that delivers a constant regulated supply of medication) was fitted and started at 5.30pm.

37. We agree with the clinical reviewer that the decisions regarding medication to control the man's pain levels and other associated actions were taken at the appropriate times.

Liaison with the man's family

38. During his imprisonment, the man was estranged from most of his family. On 11 April, he asked the chaplain to inform them that he was ill. A week later, his brother and sister-in-law visited him in his cell. Both the chaplain and the palliative care lead nurse gave them information and the contact details for those caring for the man.

39. On 23 April, after the oncologist confirmed that the man's condition was terminal, the palliative care lead nurse and the family liaison officer (FLO), met him to discuss disclosure of information to his family. The man told them he had lost contact with most of his family and was divorced from his wife, who was listed as his next of kin. The chaplain contacted the man's ex-wife, who confirmed a few days later that she would remain his next of kin.

40. During a visit from his family on 20 May, the family liaison officer and the palliative care lead nurse met the man's family members and explained their

roles. After the visit, the palliative care lead nurse explained the man's diagnosis and prognosis to them and the family liaison officer gave more detail about the support he could give them, as well as his contact details and those of other key members of staff. The man's ex-wife and his sister asked to be told when his condition deteriorated. The next day, the FLO asked staff at the prison visitors' centre to send information to his family about the Assisted Prison Visits Scheme. Healthcare staff also remained in contact with them.

41. The man's family were due to visit him during the afternoon of 25 May, the day he moved to the Retreat. However, due to his continued decline prison staff contacted them to suggest that they visited him earlier in the day. The FLO arranged transport for the man's ex-wife and accompanied her to the prison. Staff answered questions about what would happen after his death and his family asked to be contacted if the man died during the night.

42. The man died at around 11.00pm that evening. His death was confirmed by paramedics at 12.28am on 26 May, and the FLO broke the news to his family shortly afterwards. The FLO contacted the man's ex-wife again later the same day and visited her at home that afternoon with an operational manager. He maintained contact, giving support to her and the family.

43. On 6 June, the chaplain conducted a memorial service at Whatton, which was well attended by prisoners and staff. The man's funeral took place two days later and two members of prison staff, including the FLO, represented the prison. The prison met the costs of the funeral and by arrangement, the man's property was returned to his family after the funeral.

44. We believe that prison and healthcare staff effectively supported the man and his family throughout his illness. Records show many examples where his family were given timely and appropriate information during telephone calls and visits, both before and after his diagnosis, until after his funeral.

The man's location

45. At his own request, the man remained on C wing during his illness, with his friends and the staff he knew. His condition deteriorated and, on 27 March, he agreed to move to a cell on A-8 wing, which was equipped with a hospital bed and bedding, wheelchair, commode, appropriate high backed chairs and a shower stool. He also benefitted from care given by Disability Assessment Coordinators (DACs), trained prisoners who carry out basic care and cleaning tasks, but not personal care. This service ensured his environment was safe and clean, he had company and he was seen regularly throughout the day. The prison kitchen also adjusted his diet to meet his needs as his condition deteriorated.

46. On 10 May, a Community Occupational Therapist carried out an assessment. Concerns were raised about the man's safety as he smoked in bed, which was a fire risk. It was also considered it was unsafe for him to move around in his cell and that he should not be left alone when using the commode or

sitting in the chair. Healthcare staff planned to increase the frequency of staff visits and the next day, a multidisciplinary team comprising the Governor, prison and healthcare staff agreed an open-door policy to allow easy access to the man's cell. His nursing care plan was updated and an overnight carer was employed, who remained with him every night from 11 May until his death.

47. The man continued to be cared for in this cell until 25 May, when his condition deteriorated and it was evident his death was imminent. He then moved to the Retreat, where he died that night. During his illness, his family and his friends from other wings visited him regularly. The man's family had been shown the Retreat before he moved there and had been given information about his end of life care.

48. HMP Whatton has appropriate high quality accommodation for prisoners with terminal illness. We consider that the man's clinical and pastoral needs were well managed as his physical condition deteriorated. His wishes about where he felt most comfortable were respected and when he moved from his cell to A-8 and the Retreat, he was fully involved in the decision making.

Compassionate release

49. Prison Service Order 6000 outlines the circumstances under which early release on compassionate grounds may be considered and it is only granted in exceptional circumstances. Subject to a range of criteria, one of the possible grounds is where a prisoner is suffering from a terminal illness and death is likely to occur soon.

50. On 16 April, just after his illness was diagnosed as terminal, the man had a discussion with a doctor about applying for early release and said he would consider this. There is no evidence that prison managers followed this up themselves or that they discussed or considered the possibility of compassionate release. We therefore make the following recommendation.

The Governor should ensure that the possibility of compassionate release on medical grounds is considered and documented in all cases where a prisoner is terminally ill.

Palliative care plans

51. The clinical reviewer wrote about palliative care:

> "The healthcare department at Whatton are well practiced in delivering end of life care. Appropriate liaison with secondary care and with other community services was made but on the whole, was not necessary, as there were no significant management challenges and the palliative care plan in place worked well."

52. Appropriate treatment and nursing care plans were agreed, which took into account the man's wishes. His family was aware that he would die at

Whatton. As his condition worsened, the prison contracted agency care staff to cover night care and other periods when healthcare staff were not in the prison. This was principally overnight on weekdays and from 12.30 pm until 8.00am at weekends.

53. Healthcare staff ordered anticipatory medication for end of life care on 14 May and the Liverpool Care Pathway (used to guide a multi-disciplinary team in matters relating to treatment care and comfort during the end stages of life) was put in place at 10.45am on 25 May. The man moved to the Retreat at around 4.00pm that afternoon. He had been taking his medication orally until he became unconscious just before his transfer to the Retreat and was switched to injectable medication through a syringe driver at 5.30pm. This remained in place until his death later that evening.

54. Just after 11.00pm on 25 May, the man's overnight carer reported that he thought the man had died. Nottinghamshire Emergency Medical Services, Whatton's out of hours medical service provider was informed at 11.13pm. The duty doctor refused to attend and advised staff to call the ambulance service. Due to a technical problem staff were unable to get through to the 999 emergency number and the NEMS coordinator called an ambulance.

55. The prison received a call at 11.53pm to say that an ambulance was on its way. The ambulance crew rang again at 12.10am again to say that they were en route and that they would try to persuade the NEMS doctor to attend. They arrived at 12.18am. A few minutes later, the doctor telephoned to find out if the ambulance had arrived and said he would leave the paramedics to deal with the situation. The paramedics confirmed that the man had died at 12.28am.

56. We are satisfied that the prison's death in custody contingency plan was properly implemented and recorded after the initial report of the man's probable death by the overnight carer. However, it is disappointing that the prison received unsatisfactory service from NEMS, who failed to provide a competent person to certify the man's death and left the paramedics to complete the process almost one and a half hours later.

57. We agree with the clinical reviewer's conclusion that the care and support the man received at Whatton was comparable to that he could have expected in the community.

Restraints, security and bedwatch

58. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed

by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

59. The man was an enhanced prisoner under the prison's incentives scheme, which indicates that his behaviour in prison was very good. He attended several hospital appointments, at least four in the two months preceding his death, on some occasions admitted as an inpatient. Prison staff conducted risk assessments for the hospital visits, including input from healthcare staff, who annotated the document to indicate that the man required a wheelchair. The assessments covered risk to the public, risk of hostage taking; escape potential (including the likelihood of outside assistance to aid escape); risk to females and risk to hospital staff. The man was assessed as low risk on all aspects and was escorted by two prison officers on each occasion.

60. The escort documents show that officers used standard handcuffs for journeys and an escort chain while he remained in hospital. (An escort chain is a single handcuff attached to the prisoner, a length of chain then connects this to another handcuff worn by an officer). Justification for the level of escort and restraint was the nature of the man's offence. There is no indication that the escort chain was removed during treatment.

61. In view of the level of perceived risk, and the man's state of health and lack of mobility, we do not consider that the use of restraints was justified or appropriately balanced security with humanity. There is no evidence to suggest that the man presented a risk of escape or to the public that could not be managed by a two officer escort, without the use of restraints. We make the following recommendation.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

RECOMMENDATIONS

1. The Governor should ensure that the possibility of compassionate release on medical grounds is considered and documented in all cases where a prisoner is terminally ill.

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that the possibility of compassionate release on medical grounds is considered and documented in all cases where a prisoner is terminally ill.	Accepted	As part of the multidisciplinary approach to the management of terminally ill prisoners the Head of Safer Custody and the PCT Palliative Care lead nurse ensures that the possibility of compassionate release on medical grounds is considered, discussed and the outcome noted in the Family Liaison Offer log and on the prisoner NOMIS case notes.		
2	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.	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.		