PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

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

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the circumstances surrounding the death of the man at HMP Whatton. He died in July 2012 from cancer of the bladder. He was 82 years old. I offer my condolences to his family and all those affected by his death.

The investigation was carried out by an investigator. A clinical reviewer conducted a review of the man's clinical care on behalf of the local Primary Care Trust. HMP Whatton cooperated fully with the investigation.

The man had been diagnosed with cancer and completed a course of radiotherapy before his imprisonment. Hospital treatment continued when he went into prison in May 2011. He was later told that the cancer was incurable and only palliative treatment could be given. The prison respected his wishes to remain at Whatton until he died and not to contact his family until after his death.

The investigation found that there was a caring and compassionate approach to looking after the man. Indeed, he recorded before he died that healthcare staff "treated him with dignity, respect and kindness at all times". It is therefore disappointing to find that the prison considered it necessary to use restraints at hospital on such an elderly and terminally ill man who had been assessed as low risk. However, in all other respects, Whatton provided a very good standard of care for him, abided by his wishes and allowed him 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 **January 2013**

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SUMMARY

1. The man was convicted of sexual offences on 13 May 2011, and sentenced to six years in prison. He was 81 years old.

2. He transferred from HMP Nottingham to Whatton on 2 June 2011. At his first reception health screen, a nurse noted that he had been diagnosed with a malignant bladder tumour on 9 February 2010 and had completed a course of radiotherapy. He also had a nephrostomy (a thin plastic tube to divert urine from the kidney into a collecting bag outside of the body). He had to attend hospital twice weekly so that the dressing and drainage bag could be changed.

3. On 25 October 2011, a letter from the hospital advised that he had residual disease in his bladder. During a subsequent discussion with his consultant, he was informed that there was no cure and any further treatment would be palliative. He then decided that he did not wish to undergo any further interventions.

4. His clinical record indicates that he understood and accepted the extent of his illness and that 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.

5. His health deteriorated and he died in July 2012. His family were notified promptly and the prison arranged his funeral.

6. We are satisfied that the care given to him was timely and appropriate, and at least the equivalent to that he could have expected in the community. However, we are concerned that, although he had poor mobility and was assessed as low risk, restraints were used for hospital visits and during blood transfusions. We therefore repeat a recommendation made to Whatton in July 2012 about the use of restraints.

THE INVESTIGATION PROCESS

7. 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 examined documents relating to the man's time in custody. He visited Whatton on 16 August 2012 and interviewed three members of staff. He gave preliminary feedback on the findings of the investigation to the Head of Residence at the prison.

9. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf. He was given 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 contacted the man's family but did not receive a response.

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 the NHS and provided by a healthcare provider. 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.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) last inspected Whatton during January and February 2012. 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 particularly good.

Independent Monitoring Board

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

Previous deaths at Whatton

17. We have investigated a number of deaths at Whatton. The man was the seventh prisoner to die since January 2011. Like him, all of the other prisoners had serious long-term medical conditions. The investigation into the death of the fifth man found that his chronic diseases were managed well both by the prison and secondary healthcare providers, but there were occasions when the use of restraints for hospital appointments was inappropriate. This investigation found similar concerns and we repeat a recommendation about the use of restraints.

ISSUES

The diagnosis of the man's terminal illness

18. The man was diagnosed with bladder cancer on 9 February 2010 and received radiotherapy at two hospitals.

19. On 13 May 2011, he was convicted of sexual offences and sentenced to six years imprisonment. He arrived at HMP Nottingham the same day. This was not his first time in prison. At his initial health screen, it was noted that he had been diagnosed with terminal bladder cancer and had a nephrostomy in place to drain urine from the kidney and help prevent a build up. This had to be changed twice weekly. He was under the care of a consultant urologist at hospital. He also had chronic obstructive pulmonary disease (COPD) and asthma and was referred to an asthma clinic. He was described as self-caring but needed a walking stick to assist his mobility.

20. The man transferred to HMP Whatton on 2 June 2011. A nurse in reception carried out an initial health screen and noted that he was generally unwell and had a bladder tumour. She described it as a "grade 3 transitional cell carcinoma diagnosed in 2010". He was referred to Whatton's senior practice nurse and end of life lead, who saw him on 7 June. After examining him and attending to his nephrostomy, she explained her role as the palliative care lead. She also noted that he had an appointment with one of Whatton's GPs on 13 June to discuss his case.

21. After examining the man, the doctor recorded that he had first received treatment for bladder cancer in September 2010, but it was unclear whether his condition was palliative or curative. She therefore requested clarification from his hospital doctors and it was subsequently confirmed in July 2011, that radical radiotherapy had not been curative.

Informing the man about his condition and treatment

22. The man was aware of his diagnosis of malignant bladder cancer before he arrived at Whatton and he continued to have palliative treatment. Just before he went to prison his doctor indicated that he had a five per cent chance of living for two years. It was documented on his initial health screen that he commented he "would not live to the end of his sentence". He was able to discuss his diagnosis with healthcare staff, who were responsive and acted promptly when he reported symptoms. Staff actively discussed his treatment with him.

23. When it was found, in October 2011, that he had residual disease in his bladder he was fully informed of the position and indicated that he did not want to undergo any further intervention. We are satisfied that he was given information on the progression of his illness and treatment options in a considerate and timely manner.

The man's medical appointments and treatment

24. The man attended all his hospital outpatient appointments and was occasionally admitted as an inpatient. An important part of his ongoing care was changing his nephrostomy tubes, initially twice a week, later increased to three times a week.

25. He had been upset that at a hospital appointment on 19 August, which he had thought was just for a routine nephrostomy change, he had had a flexible cystoscopy (a procedure whereby the inside of the bladder is examined with a thin telescope). At a cancer care review on 26 September 2011, he told the senior practice nurse that he did not want to attend a pending consultant oncologist appointment, as he "knows what they are going to say". The following day, he signed a disclaimer confirming that he "only wants to attend for nephrostomy change, but nothing else regarding cancer treatment".

26. Four days later, on 30 September, he asked for his nephrostomy changes to be reduced to twice weekly as he found it too uncomfortable to have them every two days. This was agreed.

27. On 25 October, following an appointment at the oncology department at hospital, healthcare staff at Whatton received a letter stating:

> "Unfortunately he has residual disease in his bladder following his radiotherapy. He is not thought to be fit for a cystectomy. He is quite accepting the fact that he is likely to be in trouble and has decided that he doesn't want any further interventions. He is happy to come and have his nephrostomy changed next month."

He was further advised that any subsequent treatment would be palliative.

28. On 1 November, he had a meeting with the senior practice nurse. He said that, following a recent hospital visit, he wished to have no further chemotherapy. She discussed this with him to ensure that he fully understood the ramifications of his decision. He confirmed that he understood and that it was his choice to make.

29. This was reinforced during a consultation on 5 December, with a doctor about advance care planning, at which it was noted that he understood and accepted this prognosis. He added that he did not want any further active therapies or resuscitation, but would consider blood transfusions if they could be done at Whatton, or in hospital if they were not regular. On 19 December, he discussed with the nurse his wish not to be revived or given advanced life support if he suffered cardiac or respiratory arrest. His wish not to be resuscitated was noted on his clinical record, he signed the required form and the appropriate agencies were informed.

30. Following consultation with healthcare staff on 30 March 2012, he decided that he did not want the nephrostomy to be replaced as it was uncomfortable. Instead, he had the collecting bag placed directly over the nephrostomy outlet, later changed to a simple dressing. The following day, the doctor saw him and assessed that he had the insight and capacity to refuse the replacement of the nephrostomy tube. He signed a disclaimer to that effect.

31. In addition to scheduled appointments and treatment, there were three unscheduled emergency hospital admissions. In November 2011, he was twice admitted to hospital for a suspected blood clot on his leg. No blood clot was found. On 27 June 2012, he was taken by paramedic ambulance to the Accident and Emergency Department at hospital with a suspected fractured hip after a fall in his cell. No fracture was identified, but due to his general physical decline he was formally placed on the Liverpool Care Pathway for the Care of the Dying (a nationally recognised plan for providing palliative and end-of-life care in the last days or hours of life).

32. He was discharged the same day but, instead of returning to his cell, he moved to The Retreat, a purpose-built palliative care suite at Whatton. All the necessary drugs were ordered, overnight staff booked and the out of hours service informed in case urgent medical advice was required. He died several days later.

33. The clinical reviewer considers that the liaison between the prison and hospitals was very good at all levels. Following diagnosis, and throughout the emergency and planned admissions to hospital, the man's care was of a high standard. However, he questions whether a different approach could have been taken when the man went to hospital on 27 June with a suspected fractured hip. He believes that, subject to appropriate discussion, end of life care could have begun in The Retreat at that stage.

34. In conclusion, the clinical reviewer states:

> "The man died of incurable bladder cancer and whilst an inmate at HMP Whatton he was on a palliative care pathway. The healthcare department at HMP 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 very well".

He believes that the standard of care that the man received was comparable to that in the community.

35. We agree with the clinical reviewer's view. The man was able to make informed decisions about treatment options. An alternative approach could have been taken in dealing with his suspected fracture, but this did not impact on his cancer care and he was discharged from hospital within a day. We therefore make no criticism of Whatton's decision to take him to hospital.

The man's pain relief and medication

36. At first, the man used no pain relief as his main concern was lack of sleep rather than pain. This was treated with zopiclone. Once he needed it, his pain relief was initially managed with simple painkillers. As his condition progressed, he used both short and longer acting morphine.

37. On 6 February 2012, the doctor reviewed him. She noted that he was now suffering from pain over the bladder area. He agreed to take regular morphine in the form of 10mg of morphine sulphate tablets (MST), which act as a longer term pain reliever. Four days later, the dosage was increased to 20mg twice daily. In addition, he was also prescribed Sevredol (a shorter acting morphine based painkiller). He became confused as to the difference between the two medications and which one he should take when in pain. Healthcare staff gave him a dosette and clarified the difference between the two types of medication. By 20 February 2012, once regular morphine was established, the doctor decided that Sevredol was no longer required.

38. His medication was kept in a locked safe in his cell. When he needed to access morphine, he was able to collect the key from wing staff. No problems were recorded with him gaining access to the safe key. On 24 February 2012, he was seen taking an increased dose of morphine. He explained that he had inadvertently forgotten to take it the previous night, and had taken it the next morning in addition to the daytime dose. To avoid this happening again,

healthcare staff asked wing officers to remind him to take his evening medication. As he became increasingly frail, healthcare staff administered his medication to him. On 12 March 2012, the dosage of MST was further increased to 30mg twice daily.

39. The doctor assessed his progress on 16 April 2012, and noted that he was sleeping better with zopliclone. She also remarked that his mood had improved and his pain was better controlled. He was recorded as being content with the medication.

40. By 7 May 2012, healthcare staff noted that the man had suffered significant weight loss. He told them that he was only eating "when he felt like it". Staff made arrangements for his diet to be supplemented by cups of soup. He remained fully independent and his pain was well controlled. At this point, soft dressings were being used in place of the nephrostomy tube; he reported this as being far more comfortable.

41. A syringe driver was ordered when he moved to The Retreat but he was able to take morphine orally until he died. (A syringe driver is a small, lightweight, battery powered pump which administers pain relief under the skin).

42. We are satisfied that his pain relief was well managed. He was prescribed pain relief which he kept in his cell and took as required. Healthcare staff were responsive to his needs, and increased the medication as his condition changed

Liaison with the man's family

43. The man had no external support or family contact before or after his imprisonment. He was resolute that he did not want his family informed of his condition. The senior practice nurse told the investigator that she had several conversations with him about informing his family of his condition, but he was quite clear that he did not want his family to be contacted "until it was all over". Nevertheless, Whatton appointed a family liaison officer (FLO) several weeks before his death.

44. In June 2012, the FLO discussed with him his Will and arrangements for his funeral. It became clear that his most pressing concerns were in relation to his financial affairs and personal effects. The FLO arranged for the senior practice nurse and a member of the prison chaplaincy team to sign the statement that the man had written outlining his wishes. He stated that this was "a great weight off of my mind".

45. The man died in July. At 3.00pm that afternoon, one of the prison's operational managers, who is also a family liaison officer, visited his sister to break the news of his death and to offer support. She continued this contact and support until after the funeral had taken place.

46. A notice to staff about the man's death was displayed in the gate area and a global email sent to all prison staff. A notice was issued to prisoners. Listener co-ordinators cascaded the information to their teams to raise awareness of the impact that his death might have on vulnerable prisoners at Whatton. (Listeners are trained and supported by Samaritans to offer confidential emotional support to fellow prisoners in distress.) Special consideration was also given to prisoners who were known to have had a close relationship with him. Prison staff informed them personally.

47. Whatton invited the man's family to a memorial service, which was held at Whatton on 11 July 2012. The prison also arranged his funeral, which took place on 16 July 2012.

48. After the mans death, the operational manager contacted the bereavement team at the bank at which he held an account. She passed on all the information required, including the details of the agreed point of contact within his family. This enabled the bank to deal with his affairs as he had wished.

49. We are pleased to note that the prison complied with the man's wishes in respect of family contact and that after his death his family were told of death promptly and in person.

The man's location

50. The man had been diagnosed with terminal bladder cancer before his arrival at Whatton. With this in mind, he was accommodated in a palliative care cell on A8 wing. This was larger than a standard prison cell and equipped with a hospital bed and an en-suite shower room with a shower chair. He remained in this cell until his condition worsened and he moved to The Retreat. An occupational therapist assessed him on several occasions.

51. As he became frailer he had a number of falls in his cell during the night. He told an officer he was concerned that he might not be able to reach either of the emergency cell call buttons to summon help should he need it. The officer gave him a personal alarm (originally designed for prison officers to call for assistance). This would enable him to summon help if he was unable to reach the emergency cell call button. As it became more difficult for him to carry out everyday tasks, he was helped by a Disability Assist Co-ordinator (DAC). DACs are prisoners who volunteer to take on the role of social carer and assist prisoners, such as him, with a variety of everyday tasks.

52. Due to his illness, the man found the chair in his cell uncomfortable. On 22 February 2012, he offered to buy a reclining chair. Prisoners are not able to do this so healthcare staff arranged a comprehensive occupational therapy assessment. It was decided that a reclining chair was not practical for the space and a chair with a higher back and a replacement pillow, were supplied instead.

53. By 27 June 2012, his condition had deteriorated to the extent that it was necessary for him to move to The Retreat. Two days later, he was allowed a visit from the prisoner who had acted as his DAC. It was noted that this was of great comfort to both of them. He died several days later.

54. Throughout his illness he said he wanted to remain at Whatton. When he moved to The Retreat he told the officer that he was "glad to be home in the prison" and to "thank the staff for their help". He asked his DAC to write a letter on his behalf, praising the healthcare department, particularly the nurses and the staff of A8 who he felt "treated him with dignity, respect and kindness at all times".

55. The investigation has found that he was accommodated according to his wishes and that good efforts were made to provide appropriate aids and adaptations to meet his needs.

Compassionate release

56. Early release on compassionate grounds may be considered on the basis of a prisoner's medical condition. 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. The man did not want to apply for either compassionate release or ROTL and it is well documented that he preferred to stay at Whatton.

57. On 25 April, the senior practice nurse had a long and frank conversation with him about his life expectancy. He said that he understood and accepted his prognosis. He reiterated that he wanted his end of life care to be at Whatton and not in a hospital or hospice. It was very clear that he preferred to stay at the prison to die and his wishes were followed.

Palliative care plans

58. On 6 December 2011, the senior practice nurse initiated the Gold Standard Framework for cancer care (a systematic approach to optimising the care for patients nearing the end of their life). She spoke at length to the man and ensured that he fully understood the progressive nature of his cancer.

59. She assessed him on 19 March 2012, during a regular cancer care review. She noted that his pain was well controlled, he was well groomed, remained independent on the wing and that his cell was clean and tidy. At this point, she assessed him as Gold Standard Framework (GSF) level one, which is designed to provide supportive care.

60. On 25 April, during a further cancer care review, he was assessed as GSF level two (this notes the increasing decline in the patient's health and the need for a more intense level of care). The nurse discussed with him the options available for his end of life care when he reiterated his preference to remain at Whatton.

61. A multidisciplinary team meeting took place on 18 May, attended by representatives from Whatton's senior management team, staff from the healthcare department, residential unit staff and the family liaison officer. The main purpose of this meeting was to discuss his increasing care needs and the timing of his move to The Retreat. Further cancer care reviews took place in June.

62. On 27 June, following a visit to hospital, he was placed on the Liverpool Care Pathway, for those in the last days or hours of their life, and moved to The Retreat. By 30 June, he required full nursing care.

63. One morning in July 2012 he was being attended to by a nurse who noted that his breathing had become intermittent and shallow. By 10.40am, he had stopped breathing. The senior practice nurse verified his death at 10.50am.

64. His medical records show that medication was ordered and the Liverpool Care Pathway was started at the appropriate time. We are satisfied that timely palliative care was put in place and staff were responsive to his needs in accordance with the agreed care plan.

Restraints, security and bed watch

65. The man attended a number of hospital appointments, and occasionally stayed 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 visits, officers used standard handcuffs for journeys and an escort chain while he remained in hospital. (An escort chain has a single handcuff at either end; one attached to the prisoner the other to an officer.) The risk assessments noted that restraints would be removed for medical treatment, subject to authorisation by a telephone call to the duty governor.

66. On 27 June 2011, he went to hospital for a blood transfusion. The escort record shows that he was restrained by an escort chain during the procedure. The officers did not seek permission to remove his restraints. This same thing happened during a blood transfusion on 20 December 2011.

67. Risk assessments for these hospital visits 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 (including the likelihood of outside assistance to aid escape) risk to females and risk to hospital staff. In all of these areas the risk posed by him was assessed as low. Despite this, he was handcuffed during journeys and twice subject to restraints during treatment.

68. 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.

69. 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 restraining by handcuffs of 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.

70. The man was elderly, with poor mobility. He used a walking frame to get around and a wheelchair for hospital visits. The Head of Security and Operations described him as "a very poorly man". He said that the standard level of restraint would normally be a single handcuff. This would be downgraded to an escort chain in certain situations such as if the prisoner was in a wheelchair and/or their mobility was poor. The possibility of being escorted without restraints does not appear to have been considered.

71. As the man was judged to be low risk against all of the assessed criteria, we do not consider that the use of restraints was justified. Two escort officers should have been sufficient for security purposes, and it was unnecessary to subject an elderly and terminally ill man to the indignity of having to attend hospital chained to an officer. We therefore repeat the following recommendation, which was made to Whatton in a previous investigation which concluded in July 2012.

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

CONCLUSION

72. The man had been diagnosed with terminal cancer before his arrival at Whatton. As his condition deteriorated, the care given to him by prison healthcare staff was of a high standard, at least equivalent to that available in the community, and his views were taken into consideration at every stage. His medical records show that the level of liaison between healthcare staff and the secondary care providers was of an acceptable standard.

73. Every effort was made by Whatton to assist him with the matters that were of concern to him in his final days. We are pleased to note the level of commitment shown by Whatton in assisting him with his personal affairs in addition to his clinical needs. It is clear from his comments that this was of great comfort to him at an already difficult time.

74. We are satisfied that his clinical care was appropriate. However, we do not consider the use of restraints to attend hospital appointments, or while undergoing procedures such as a blood transfusion, was always justified by the prison's own risk assessment.

RECOMMENDATION

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

The prison service accepted the recommendation and their response was:

> *"The Head of Security and Head of Residence now discuss "patients of note" with our GP's on a regular basis and take advice on medical grounds that may influence the Security risk assessment.*
>
> *"Senior managers have been instructed to fully document reasons for the continued use of restraints. Bedwatch staff are also 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 are to be included in the establishment LSS and prisoner escort packs."*