

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at hospital in  
January 2013, while in the custody of HMP Whatton**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man at hospital in January 2013, while a prisoner at HMP Whatton. He was 38 years old and died from peritonitis as a result of metastatic melanoma (skin cancer). I offer my condolences to his family and friends.

A clinical reviewer reviewed the man's clinical care at Whatton. The prison cooperated fully with the investigation.

The man was released on licence from prison in 2007 but recalled in 2009. Shortly before his recall, he had been diagnosed with cancer. He had recurrent tumours, which were removed and treated, followed by a period of remission. In December 2012, his doctors found that the cancer had spread to other areas of his body and was incurable. He was given a short life expectancy of three to four months, but his condition deteriorated far sooner than expected.

Healthcare staff at Whatton could not have anticipated the man's relapse in 2012 or the acute episode which resulted in his death. I agree with the clinical reviewer that the standard of medical care received by him at the prison following his prognosis was generally caring, sensitive and professional. However, there was an inexplicable and unacceptable delay in responding to his request for medical attention when he took a turn for the worse in January, and I do not believe the use of handcuffs until shortly before he died was justified.

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 2013**

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## SUMMARY

1. The man was convicted of serious offences on 19 April 2000 and sentenced to 12 years in prison. He was released in 2007, but recalled to prison in March 2009, after he breached the conditions of his licence. In December 2008, while living in the community, he had been diagnosed with skin cancer. Between 2009 and December 2011, he had a number of tumours removed. He had a brief respite from the disease during a nine month period at HMP Northumberland. He returned to Whatton on 21 September 2012.
2. The man was diagnosed with terminal cancer on 19 December 2012 and informed of his condition two days later. Doctors assessed he had up to four months left to live, but he did not want to know this information. Staff at the prison supported him throughout his illness and facilitated a family visit in a private room on 23 December, so he could tell them of his diagnosis. The lead nurse offered him a move to a cell better suited to his needs but he declined as he wished to remain with his friends on his Wing.
3. In January 2013, the man attended an outpatient appointment at the oncology department, where an MRI scan<sup>1</sup> was performed. During the return journey to Whatton, he complained of severe abdominal pains. When he arrived at the prison, a nurse advised him to take pain relief and report to wing officers should his condition worsen. Between 9.30pm and 10.00pm, he called for help but there was a delay in responding as officers were dealing with another emergency. On the advice of the out of hours emergency service, staff arranged for him to be taken to hospital by emergency ambulance. He did not leave the prison until sometime after 2.00am.
4. At 8.35am the next morning, the man asked for his family to be notified of his admission to hospital. There was some delay in contacting his family but they were able to be with him when he died just after 4.00pm.
5. We are satisfied that the man's health was well managed at Whatton. He was appropriately referred to an oncologist and given good support and care after his diagnosis. The initial referral went astray, but the clinical reviewer concluded that this did not have any adverse impact on his condition.
6. The response to the man's worsening condition and request for medical attention the night before he died was not handled so well. Delays in responding to him and dealing with the necessary administration when he reported increased and severe pain meant it was several hours before he was taken to hospital. His subsequent request for his family to be told of his admission was not actioned with any haste, in spite of his critical condition. We are also concerned that he was assessed as being a higher risk when his condition declined significantly, than his risk earlier in the day for an outpatient appointment. As a consequence, he was held in handcuffs until a few hours before his death. We make recommendations on these issues.

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<sup>1</sup> MRI Scan – Magnetic resonance imaging – used to diagnose health conditions that affect organs, tissue and bones

## THE INVESTIGATION PROCESS

7. Notices about the investigation were issued to staff and prisoners, inviting anyone with relevant information to contact the investigator. No one came forward. She visited Whatton on 14 March 2013 and met the Governor and a member of the Independent Monitoring Board. She obtained copies of the man's prison and medical records and visited various parts of the prison, including his cell. She interviewed four members of staff and gave preliminary feedback to the Governor.
8. The local PCT commissioned a clinical reviewer to conduct a clinical review of the care the man received at Whatton.
9. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. The investigation report has been sent to the Coroner.
10. One of the Ombudsman's family liaison officers spoke to the man's mother about the investigation process. She had no specific issues for the investigation to cover. The family received a copy of the draft report as part of the consultation process however they had nothing further to add.
11. 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 appropriate palliative care provided.
12. The Prison Service response to recommendations and action plan are attached to this report.

## **HMP Whatton**

13. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 male prisoners. All the prisoners are sex offenders.
14. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Community Health Trust. The healthcare centre is open daily from 8.00am to 7.30pm, with a local out of hours service providing cover at night and at weekends. Specialist clinics are provided for older prisoners and those with life long conditions. There are no inpatient beds at Whatton.

## **HM Inspectorate of Prisons**

16. 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. Palliative care arrangements were described as excellent.

## **Independent Monitoring Board**

17. 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 annual report, for the period to May 2012, the IMB at Whatton reported favourably on healthcare services. 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**

18. The man was the sixth prisoner to die of natural causes since January 2012. Like him, all the other prisoners had long-term medical conditions. In recent investigations we have found that there were occasions when the use of restraints for hospital appointments was inappropriate. There are similar concerns in this case.

## ISSUES

### The diagnosis of the man's terminal illness

19. The man was convicted of serious offences on 19 April 2000 and sentenced to 12 years in prison. He had no serious medical conditions at that time. He was released in 2007. He breached his licence conditions and on 14 March 2009, he was recalled to prison and taken to Whatton.
20. In December 2008, before he returned to prison, the man had been diagnosed with malignant melanoma (skin cancer). From 2009, he had recurrent tumours, which were treated and removed. His last operation was in December 2011 and the hospital advised the prison that the tumour had been completely removed. He transferred to HMP Northumberland in January 2012. Throughout his time there, he was in remission and displayed no symptoms but he was subject to three-monthly checks.
21. On 21 September 2012, the man returned to Whatton. On 22 October, a prison doctor reviewed him. At his request, the practice manager sent a routine referral letter to his oncology consultant on 25 October, to resume his follow-up appointments. This letter was never received. On 23 November, he complained to another of the prison's doctors of dizziness, blurred vision, headaches and being unsteady on his feet for the previous two weeks. The doctor immediately contacted the oncology department, who advised they had not received the original referral letter, so a second letter was faxed urgently.
22. The man's symptoms continued and his vision deteriorated. He attended an appointment at the oncology department on 3 December, and had an MRI scan on 12 December. This scan identified that the cancer had spread to his brain and that his condition was terminal. His doctor predicted a life expectancy of three to four months.
23. In relation to the initial referral in October 2012, the clinical reviewer commented:

'Unnecessary administrative delays can be critical in the management of cancer referrals. Although this delay did not impact on the course of his cancer, delays like this should be avoided.'
24. We are satisfied that the diagnosis of the man's terminal illness was appropriate. Although it is unclear when and where the initial referral went astray, we consider that healthcare staff should have followed it up when there was no reply from the hospital. We make the following recommendation:

**The Head of Healthcare should ensure there is a clear and auditable process for hospital referrals which are followed up, when there is a delay.**

## **Information about the man's condition and treatment**

25. A doctor telephoned the hospital on 19 December, to discuss the results of the man's scan carried out the week before. At a review on 21 December, the doctor told him the disease had spread to his brain and that it was inoperable and incurable. He indicated he did not wish to know his predicted life expectancy. He agreed to have steroid therapy and discussed the possibility of radiotherapy. After the review, the senior practice nurse and end of life lead gave him the opportunity to discuss his diagnosis. He again made it clear that he did not wish to know his prognosis.
26. We are satisfied that the man was given information about his illness and treatment options in a sensitive and timely manner. Healthcare staff respected his wish not to know his life expectancy.

## **The man's appointments and treatment following diagnosis**

27. After his diagnosis, the man immediately started steroid therapy. He had regular reviews with the prison doctor and cancer care nurse and took medication to alleviate his symptoms. On 2 January, the prison doctor reviewed his medication and prescribed additional anti-inflammatory medication and antacids. He attended an oncology appointment on 7 January 2013, where he received a further MRI scan. This showed that the cancer had spread to his pancreas and small bowel (however, neither he nor prison staff were aware of this at that time).
28. The man returned to Whatton at 6.15pm that evening, and complained of abdominal pains on the journey back. A nurse assessed him in reception and carried out clinical observations, which were normal. The nurse noted that he had some abdominal discomfort and that he had described the pain as like 'trapped wind but worse'. The pain eased and the nurse advised him to return to his wing, take some pain relief and notify officers if he had any further problems. The escorting officers took him back to his wing and informed wing officers what the nurse had said and that they should contact the Nottingham Emergency Medical Services (NEMS), the prison's out of hours service, should his symptoms worsen. A brief note was recorded in the wing observation log.
29. According to an officer, the man rang his cell bell at 9.30pm that night and then again at 10.30pm. The officer spoke to him, who complained of severe abdominal pains. The officer reported this to the night manager, who was dealing with another serious incident in the adjacent cell and said that he would deal with him as soon as possible. (This other prisoner required urgent medical assistance and the control room log notes an ambulance arrived at 9.34pm and left at 9.38pm.)
30. The officer estimated that the man rang his cell bell again around an hour after his first call and, this time, he went into the cell with another officer. He told the officers that the pains were 'really bad' and rated them at nine on a scale of one to ten. He also told the officers that he had been to hospital

earlier that day and had reported some abdominal pain when he returned. The officers decided to contact NEMS. One officer, who was aware that he had cancer, spoke to the on-call doctor, at 12.45am. The man spoke to him too. The doctor then advised staff to send him to hospital immediately. The officer described him as pale and sitting hunched in pain. An ambulance was called at 1.02am. It arrived at 1.40 and he was taken to reception in a wheelchair at 1.55am. He waited there while the night manager completed the documents to accompany him. The ambulance left the prison at 2.25am and arrived at hospital at around 2.45am.

31. The night manager recorded that after he dealt with the prisoner in the cell next door to the man, he went to A wing to carry out his rounds with an officer. He then received a message that the man had rung his cell bell complaining of severe stomach pains. He knew that he had been at hospital earlier that day and healthcare staff had examined him when he returned, so he decided to continue his rounds. About an hour later he received a second call about him, but said as he was making his way to the cell, he was called away to deal with further actions arising from the earlier incident. He therefore asked the officer to attend to him. There is a discrepancy between the timings given by the officers. The night manager believes that the officers' times are incorrect but the entries in the prison records were brief and untimed, so the investigator was unable to resolve the inconsistencies.
32. Hospital doctors diagnosed a perforated bowel. The clinical reviewer comments that 'it is likely that the bowel perforation occurred during the early afternoon and evening of 7 January,' and 'the man had a very long and uncomfortable day and it was likely that by 9.30pm the pain had become unbearable'. He notes that at each stage in the diagnostic and referral process there was a delay. In this case, this equated to between four and five hours before he received medical attention. The cell bell records were unavailable so the investigator was unable to clarify the discrepancies between the timings reported by officers.
33. The man's symptoms and pain had gradually worsened throughout the day. We are unable to confirm exactly when he pressed his cell bell for assistance. However, it is clear there was a significant and unacceptable delay of over two or three hours before staff called a doctor, a further delay of several minutes before they acted on the doctor's instructions to send him to hospital by ambulance and he was then made to wait in reception for a lengthy period for administrative actions before the ambulance could leave.
34. It is essential that in clinical crises prisoners have rapid access to appropriate emergency services as timely care can improve clinical outcomes for patients. Although some staff were attending to another prisoner, we consider that others should have been deployed to assist the man. We therefore make the following recommendation:

**The Governor should ensure that night staffing arrangements and procedures allow prompt attention to prisoners who need medical assistance and that there is no delay in sending prisoners to hospital.**

**The man's pain relief and medication**

35. After the man's diagnosis on 21 December, he was prescribed pain relief (paracetamol and diclofenac) together as well as steroid therapy. His headaches improved and, on 2 January 2013, a doctor adjusted his medication and added anti-inflammatory and antacids. His medication was delivered to his cell and kept in a secure medication locker, to which he had exclusive and unrestricted access. We are satisfied that his pain relief and medication was managed appropriately at Whatton.

**Liaison with the man's family**

36. On 23 December, a nurse, the end of life lead, arranged for the man to have a visit in a private room to tell his family about his diagnosis. He gave the nurse permission to speak to his family about his illness but not his life expectancy. His mother discussed her concerns with staff and requested permission to attend his next oncology appointment. For security reasons, this was not granted.
37. A prison family liaison officer was appointed on 24 December. He did not contact the man's family until 8 January, after he was taken to hospital seriously ill, as for most of that period his family were abroad on holiday.
38. At 8.35am, after his admission to hospital in the early hours the morning, the man asked prison staff to contact his mother and sister. One of the escort officers passed his request to an operational manager. She did not contact his family, but at 9.30am, she asked a SO to go to the hospital for an update on his condition. The SO arrived at the hospital at 11.15am and was told that he was extremely ill and not expected to live beyond 24 to 48 hours.
39. The SO telephoned the man's mother from the hospital at 12.30pm. He told her that her son had been admitted to hospital, was seriously ill and that his family could visit him any time and stay for as long as they wished. After he was the appointed family liaison officer, the SO did not stay at the hospital to meet the family, but returned to the prison. The family arrived at 1.45pm and stayed with him until he died at 4.04pm.
40. The operational manager and the end of life lead arrived at the hospital shortly after the man's death and spoke to his family. They offered and provided extensive support. This included performing tasks outside of their remit, normally carried out by hospital staff, to assist his mother and sister. We commend them for their action and sensitivity.
41. Although the prison had appointed a family liaison officer shortly after the man's diagnosis and two weeks before died, he did not contact the family until the morning of his death. We make no criticism of the original delay in

contacting them, as they had gone on holiday on the day he was appointed. However, we are concerned at the delay in informing his family when he was taken to hospital on 7 January.

42. Prison Rule 22 (1) states:

“If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, 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.”

43. In line with the Prison Rules, NOMS guidance advises prisons to engage with the prisoner’s next of kin or another nominated person in the event of a terminal illness or unpredicted/rapid deterioration in physical health. When the man asked staff to contact his family, it took four hours for this to be done. If his family had been contacted earlier in the day, it would have given them additional precious time with him before he died that afternoon.

44. We are surprised that the prison’s family liaison officer left the hospital after calling the man’s family and did not wait to meet them. As the prison’s primary contact and, as a matter of good practice, we consider that he should have remained at the hospital until they arrived, 75 minutes later.

**The Governor should ensure that the next of kin of prisoners who become seriously ill are informed quickly and are appropriately supported by a nominated member of staff.**

### **The man’s location**

45. After the man’s terminal diagnosis the end of life lead offered him a cell on A8 wing, which has bigger cells and would be safer for him given his failing eyesight. However, he preferred to remain on B Wing with his friends over the Christmas period, where he felt well supported. Staff respected his decision and arranged a meeting in January to review the suitability of his location. Unfortunately, this issue was not discussed again as his condition deteriorated so quickly and unexpectedly. We are satisfied that staff considered the suitability of his location and consulted him appropriately as his illness progressed.

## **Compassionate release**

46. Early release on compassionate grounds may be considered on the basis of a prisoner's medical condition. It is only granted in exceptional circumstances. One of the criteria for considering early release is that the prisoners are usually expected to have less than three months to live. There is no indication that the prison considered applying for release on compassionate grounds for the man but, as he did not wish to know his life expectancy, we accept it would have been difficult to discuss such an application with him. Unfortunately, there was no further opportunity to make an application as his condition declined so rapidly.

## **Palliative care/end of life pathways**

47. After his diagnosis, healthcare staff at Whatton placed the man on the Gold Standard Palliative Care Framework and gave him appropriate pain relief. However, in accordance with his wishes, they were unable to discuss end of life care plans with him at that stage. The end of life lead intended to broach this with him at a later date.
48. The clinical reviewer comments that the man required significant healthcare input at Whatton and that nursing staff should be commended for their skill in addressing his needs. He said:

‘The level of care was particularly sensitive to his emotional needs. Nursing staff especially went to great lengths to help him cope with the continued spectres of recurrence of his cancer.’

49. We agree with the clinical reviewer that the level of care given to the man was caring, sensitive and professional.

## **Use of restraints, security and bed watch**

50. 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 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.
51. 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.

52. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others.
53. Prison staff carried out a risk assessment for the man's outpatient hospital appointment (blood tests) on 7 January. Healthcare staff ticked the form to indicate that there was no medical objection to the use of restraints. The level of risk was assessed against risk to the public, risk of hostage taking, risk of escape and risk to hospital staff. In all these areas, the risk posed by him was assessed as low. Despite this, staff were instructed to use a single handcuff (one cuff attached to the prisoner's wrist and the other to an officer) for the journeys. It was noted that the restraints could be removed for medical treatment and an escort chain (single handcuffs with a length of chain about 1.5 metres long) applied if he wished to use the toilet. It is not documented in the prison escort record that the restraints were removed when he had blood tests.
54. Less than 24 hours after his outpatient appointment the man was assessed as a medium risk for his admission to hospital. Single handcuffs were used, with a directive that restraints should be removed only with prior approval from the Governor. Again, staff were permitted to substitute an escort chain if he wished to use the toilet. Prison Service guidance is that restraints are not normally necessary during an escort when the prisoner's mobility is severely limited. He was described by one of the officers as hunched over with severe stomach pains and needed a wheelchair to be moved from his wing to reception and then to the ambulance.
55. The man was sent for an MRI scan, his restraints were removed and then re-applied. The escort log shows that at 8.30am, prison staff were informed he was 'very unwell', he was to remain in hospital and pain relief was administered. He remained in bed with restraints in place until the palliative care nurse asked for them to be removed at 11.50am. She explained that he was dying and that she needed to insert a syringe driver for medication to control his pain. The Governor authorised the removal of his handcuffs at 12.15pm. He died at 4.00pm.
56. The man was judged to be low risk against all of the assessed criteria at his outpatient appointment. The risk assessment for his admission to hospital less than 24 hours later, when his mobility was restricted and his condition had deteriorated, unaccountably concluded that his level of risk was higher. There is no explanation for either the raised level of risk or the inconsistency in a relatively short period. There was no evidence to suggest that he presented a risk of escape or risk to the public that could not be managed by a two officer escort. In the light of the severity of his condition and his limited mobility, we believe it was unnecessary to subject a terminally ill man to the indignity of being admitted to hospital chained to an officer. We therefore repeat the following recommendation that we have made to Whatton in previous investigations:

**The Governor should ensure that risk assessments for hospital escorts fully consider the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.**

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure there is a clear and auditable process for hospital referrals which are followed up, when there is a delay.
2. The Governor should ensure that night staffing arrangements and procedures allow prompt attention to prisoners who need medical assistance and that there is no delay in sending prisoners to hospital.
3. The Governor should ensure that the next of kin of prisoners who become seriously ill are informed quickly and are appropriately supported by a nominated member of staff.
4. The Governor should ensure that risk assessments for hospital escorts fully consider the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

## ACTION PLAN: **The man - HMP Whatton**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure there is a clear and auditable process for hospital referrals which are followed up, when there is a delay.	Accepted	A procedure has been put in place that ensures that for any referral made where there is a delay in issuing an appointment, an alert will highlight the delay which will enable staff to follow this up.	Complete and being monitored by Healthcare Manager	
2	The Governor should ensure that night staffing arrangements and procedures allow prompt attention to prisoners who need medical assistance and that there is no delay in sending prisoners to hospital.	Accepted	<p>The Functional Head with oversight of the management of nights has taken steps to ensure that the night managers are fully aware of their responsibilities in relation to medical assistance required by prisoners during night state.</p> <p>Particular attention will be paid to ensure that any prisoner who is required to be transported to hospital the delay is minimal.</p>	November 2013	
3	The Governor should ensure that the next of kin of prisoners who become seriously ill are informed quickly and are appropriately supported by a nominated member of staff.	Accepted	In this particular case our Palliative Nurse specialist met with the man and his family shortly after his poor diagnosis to support him while he informed his family of his prognosis.	Complete	

4	The Governor should ensure that risk assessments for hospital escorts fully consider the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.	Accepted	We have already made improvements to our systems and have worked hard to ensure our risk assessments take into consideration all factors including the medical condition of the prisoner.	Complete	
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