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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the circumstances surrounding the death of a man at hospital in January 2012, while a prisoner at HMP Lowdham Grange**

## ***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 who died in January 2012 at HMP Lowdham Grange. He was 51 years old and died of a retroperitoneal haemorrhage arising from a ruptured renal cyst. I offer my condolences to his family and friends.

A clinical review was conducted of the man's care during his time in custody. HMP Lowdham Grange cooperated fully with the investigation. I apologise for the delay in issuing this report.

Before he went to prison the man had a number of complex medical conditions, for which he had been prescribed a range of medications. He first reported blood in his urine in February 2011 and was subsequently treated for deep vein thrombosis, kidney disease and prostate cancer. He had a fear of needles and often declined to have blood tests which were necessary to help calibrate the correct dosage of medication to treat his thrombosis. It is possible that this was a contributory factor in his death as this made it difficult to establish the correct dose accurately. On 11 January 2012, he suffered severe breathing difficulties and was taken to hospital as an emergency. His condition deteriorated and he later died.

The man saw healthcare staff at the prison often but he did not always comply with his treatment. Overall, the clinical reviewer concludes that the standard of care he received was equivalent to that he might have expected in the community. However, there were some deficiencies and, in particular, it took too long to refer him for specialist treatment after he first reported blood in his urine. After his diagnosis of cancer, he received appropriate treatment but a urology operation due to take place a week before he died was cancelled, apparently because he had been told the date, which was not a sufficient reason to postpone his health treatment. I am also concerned that some risk assessments for the use of restraints completed for escorts to hospital did not appropriately reflect his individual circumstances and risk at the time.

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**

**October 2013**



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## SUMMARY

1. The man was remanded into custody in January 2007 and sentenced to 12 years imprisonment the following year. He transferred to Lowdham Grange on 1 October 2008 and at that time his medical notes stated that he had type II diabetes, asthma and morbid obesity.
2. On 1 February 2011, the man told a nurse that there was blood in his urine (haematuria). A urine sample was sent for analysis and a doctor prescribed antibiotics and ordered blood tests. By 21 February, he said he no longer had blood in his urine and the doctor considered that the haematuria had been caused by an infection, which had been successfully treated. The blood test results showed that his kidney function was reduced and a doctor sent him for a scan of his kidneys and prostate. After three weeks, healthcare staff at the prison learned that the urine sample had been delayed in reaching the hospital and was too old to be useful. Another sample was sent on 26 March. Two days later, he saw the doctor again and reported blood in his urine.
3. Over the next two months, the man frequently saw doctors, suffering with haematuria, pain in his back and left leg and difficulty in urinating. On 24 May, a doctor noted that his prostate was enlarged and referred him to hospital under the urgent two-week referrals procedures for suspected cancer. The clinical reviewer states that, while it was acceptable to treat the haematuria initially with antibiotics, the referral to a specialist should have been made much earlier. He described haematuria as a “red flag” symptom that needs close and urgent attention.
4. The man spent from 6 June to 15 July in hospital, during which time prostate and bone cancer was confirmed, a deep vein thrombosis (DVT) diagnosed and he had an operation to insert a metal rod into his left thigh to counter the effects of the cancer in the bone. Once he was strong enough, he had a course of radiotherapy.
5. The treatment for the DVT was warfarin and enoxaparin, medications to thin the blood. When taking warfarin, staff needed to take blood to check the INR score and adjust the dose as necessary. Staff found it technically difficult to take blood and the man had a needle phobia and sometimes refused to allow staff to even try. Therefore, there were periods when the INR was not monitored as closely as it should have been.
6. In November, the man was reclassified as a category D prisoner, the lowest security category. He expected this to mean that he would no longer be handcuffed on his hospital visits. However, the risk assessment did not acknowledge his new security status and concluded that he should be restrained. He refused to be restrained, and prison staff refused to allow him to leave the prison. The hospital appointment did not take place. The issue was resolved by the time of his next hospital visit on 15 December, when he attended a pre-operative clinic. One of the hospital staff told him that his operation for a blocked catheter was set for 5 January 2012. However, it did

not take place on that date and the medical record indicates that this was because he had been told the date of the operation.

7. On 11 January, the man was taken to hospital as an emergency admission with a suspected clot on the lung. The next day, he was diagnosed with cellulitis (an infection in the deeper layers of the skin) and treated with intravenous antibiotics. A few days later his condition deteriorated and he was moved to the high dependency unit. He was given a blood transfusion but continued to deteriorate and he died.
8. The post-mortem report stated that the man's death was caused by a retroperitoneal haemorrhage, as a result of a ruptured renal cyst. The clinical reviewer explains in his report that this means he died of a bleeding cyst from his kidney, which filled the space around the kidney.
9. Although the clinical reviewer concluded that overall the man's care was equivalent to that he would have expected in the community, there were some shortcomings and we have made recommendations about referrals for haematuria obtaining blood samples and ensuring appropriate access to GPs. We are also concerned about the cancellation of his operation on 5 January, without a clear explanation, and the failure to use up to date information in security risk assessments for escorts. We make recommendations about those matters.

## THE INVESTIGATION PROCESS

10. Notices announcing the investigation and its terms of reference were issued to staff and prisoners at Lowdham Grange asking anyone with relevant information to contact the investigator. Several prisoners contacted her and she interviewed two of them.
11. The investigator visited HMP Lowdham Grange on 23 January 2012, and met the Deputy Director, members of the Independent Monitoring Board, representatives of the Prison Service Union and the prison's family liaison officer. She was shown the cell where the man had lived. She reviewed his prison and health records. She returned to the prison on 30 April and 1 May, to interview staff and prisoners.
12. A clinical reviewer carried out a review of the man's medical care at Lowdham Grange, on behalf of the local PCT.
13. The investigator notified HM Coroner of the investigation. A copy of this report has been sent to the Coroner.
14. One of the Ombudsman's family liaison officers contacted the man's mother and his partner to explain the investigation process and allow his family to identify any relevant issues they wished the investigation to cover. His partner was seriously concerned about the standard of his clinical treatment at Lowdham Grange. A family liaison officer contacted the family as part of the draft consultation process. They raised a concern about the issue of medication to him while in hospital care. However this matter falls outside the remit of this investigation.
15. We are sorry for the delay in issuing this report. This was due to staff changes and a backlog of work in the office which we are striving to clear.
16. The prison service response and action plan has been added to this report.

## **HMP LOWDHAM GRANGE**

17. HMP Lowdham Grange is a category B training prison, managed by Serco, which holds over 900 male prisoners. The accommodation is made up of five houseblocks, which typically hold 120-130 prisoners on three or four residential wings.
18. General healthcare services are provided by Serco. The local Primary Care Trust provides secondary mental health care services.

## **HM Inspectorate of Prisons**

19. A full, announced inspection of Lowdham Grange took place in March 2011. The inspectorate found that the prison was “an impressively safe and decent place”, and that staff-prisoner relationships were good.
20. With regard to health services, inspectors commented:

“The health care service was undergoing a period of change. There were long waits to see a doctor and dentist and prisoners were very critical of this. There was also a high ‘did not attend’ rate. Facilities had expanded to accommodate the growth in population, but staffing had not increased sufficiently.”

## **Independent Monitoring Board (IMB)**

21. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its annual report for 2011-12, the Board noted the appointment of a new Head of Healthcare and subsequent improvements in service. However, the Board considered that waiting times to see a doctor were too long and further improvements in health services were still needed.

## **Previous investigations at Lowdham Grange**

22. In the five years before the man’s death, there were two other deaths from natural causes at Lowdham Grange. There were no similarities with the circumstances of his death.

## KEY EVENTS

23. The man was remanded into custody on 6 January 2007, charged with drugs offences. On 12 September 2008, he was sentenced to 12 years imprisonment. He spent several years at HMP Nottingham before transferring to Lowdham Grange on 1 October 2008.
24. The man's medical notes indicate that he was prescribed medication for type II diabetes. He also had asthma and morbid obesity. On 24 October, his weight was noted to be 137 kg. The clinical reviewer details the range of medications he was on for his health problems. Our report focuses on the kidney disease and cancer that eventually led to his death.
25. On 1 February 2011, the man told a nurse, that there was blood in his urine. A urine sample confirmed the presence of blood and was sent for analysis. Two days later, a doctor prescribed antibiotics and ordered blood tests. He had three further healthcare appointments in February. The medical notes for a doctor's appointment on 21 February, state that he no longer had blood in his urine. The doctor considered that the blood had been caused by an infection, which the prescribed antibiotics had successfully treated.
26. On 1 March, after receiving the results of blood tests, the doctor noted that the man's kidney function was reduced and referred him for an "ultrasound KUB", a scan to evaluate the urinary tract. Three weeks later, a further note showed that analysis of the urine sample had showed blood and protein, but the sample had taken too long to reach the laboratory and could not be fully analysed. A new urine sample was sent.
27. On 28 March, the man attended the healthcare centre because he had blood in his urine again. He also said that he had back pain, severe pain in his left leg and was having difficulty sleeping because of the pain.
28. On 1 April, the doctor noted that the results of the analysis of the urine sample had still not been received. He noted that, if the presence of blood was not caused by an infection, there would have to be further investigation. It was then two months since the doctor had sent the original urine sample for testing and doctors still did not know whether the blood in the man's urine was caused by an infection or something potentially more serious.
29. On 7 April, blood tests showed that the man's kidney function was still reduced, but his blood count and liver function were normal. He told the doctor on 20 April, that he was having trouble urinating. The doctor asked for the ultrasound test which had been requested on 1 March to be chased up. His urine showed the presence of both blood and protein. (Protein in urine can be a sign of kidney disease.) The doctor prescribed antibiotics for a presumed infection. However, later the same day, the results from the updated urine test indicated that there was no infection but there were some red blood cells present.

30. On 26 April, the man again reported urinary problems and a different doctor changed the antibiotics. Another urine test showed no evidence of an infection and the red blood cells in the urine had reduced to normal levels. Despite these results, the doctors continued to treat him with antibiotics and did not refer him to a hospital specialist.
31. On 13 May, the man told a nurse that he had pain in his upper right leg and suspected he had a deep vein thrombosis. The nurse examined him and recorded that both legs were symmetrical and there was no sign of swelling or redness. The nurse referred him to the doctor and, because he was complaining of pain, his appointment was prioritised. At the time, routine doctors' appointments took an average of six weeks.
32. The man was still waiting to see a doctor on 21 May, when he told a nurse he still had pain in his left thigh and had blood in his urine again. The nurse told him that he was due to see the doctor three days later on 24 May, but noted that he was "extremely anxious". The nurse gave him an ice pack and crutches and carried out a urine dipstick test, which was negative. Nurses then saw him each day until his doctor's appointment. He complained of knee pain and said that, on one occasion, he had been unable to pass urine. On 23 May, a nurse offered the option of having a catheter fitted, but he declined. The nurse noted that he was due to see the doctor the next day.
33. On 24 May, a doctor examined the man and noted the frequent instances of blood in his urine. He checked his prostate, which he found to be abnormal. He tried to check his bladder but found it difficult because of his weight. He suspected that it might be urological cancer and, the same day, referred him to a specialist under the two-week urgent referral guidelines for suspected cancer.
34. On 2 June, healthcare staff received a letter from hospital staff, asking them to take blood tests from the man before his admission to hospital four days later on 6 June. He refused to allow staff to take blood and signed a disclaimer form. His medical records refer to his "needle phobia" and document that staff sometimes had difficulty in drawing blood from him.
35. The man was admitted to hospital on 6 June for tests. The results showed that he had prostate cancer which had spread. He was treated with hormone therapy. The secondary tumours included the left iliac lymph nodes (nodes on arteries that supply blood to the pelvic organs, gluteal region, and legs) and the left proximal femur (part of the femur closest to the torso). He had a blood transfusion and was prescribed fentanyl patches (an opioid analgesic) to control his pain. He was also given oxycodone (an opioid painkiller related to morphine) for breakthrough pain. He was fitted with a long term catheter that needed to be changed every three months.
36. The man was also diagnosed as having a deep vein thrombosis (DVT - the formation of a blood clot in a deep vein, most commonly in the legs). He was treated with warfarin (a medication to stop blood clotting) and needed regular

blood tests to monitor this. Doctors also noted that his type 2 diabetes was currently controlled by diet but needed to be monitored.

37. On 3 July, the man had an operation to insert a rod into the bone marrow canal to stabilise his left thigh bone as the cancer had spread. Hospital and healthcare staff discussed his medication needs to ensure that he had enough medication when he returned to prison. When he returned to Lowdham Grange on 15 July, he was prescribed additional medication which he was able to keep in his cell and administer himself.
38. The dosage for patients taking warfarin is normally monitored once or twice a week using the international normalisation ratio (INR), which measures how long it takes the blood to clot. The man's fear of needles meant that monitoring his INR reading was not always straightforward but it was checked frequently and the dose of warfarin adjusted as necessary.
39. After he returned to the prison on 15 July, healthcare staff saw the man regularly. They gave him oxynorm for additional pain relief every four hours up to the maximum dose set by hospital staff. The main painkiller (fentanyl, which is stronger than morphine) was administered through a patch.
40. On 20 July, one of the doctors examined the man and changed the fentanyl patch to morphine sulphate pills, twice daily. By this time, the diagnosis of prostate cancer had been confirmed, along with the secondary tumour on his thigh bone. The doctor referred him to the tissue viability nurse for care of his leg ulcers and leaking blisters. She reviewed him on 2 August and drew up a care plan to treat his worsening skin condition. On 3 August, a further care plan was started to monitor his daily activities, daily fluid balance and his level of breathlessness.
41. On 25 July, the disability liaison officer visited the man and assessed his needs. She ordered a mattress protector, support pillows and bed relaxers. Prisoner A was employed as his carer.
42. By 5 August, the man's breathlessness had worsened and healthcare staff carried out an electro cardiogram (ECG), a test to record the rhythm and electrical activity of the heart. The result was abnormal and he was taken to hospital as an emergency admission. After tests, hospital staff advised prison healthcare staff that he was suffering from heart failure.
43. After a week in hospital, the man returned to the prison. He asked a doctor to increase his pain medication and for healthcare staff to manage all his medications as he did not feel able to do so himself. On 19 September, the hospital decided he was well enough to begin radiotherapy.
44. On 5 October, the man had a doctor's appointment for a review of his cancer care. The doctor noted that he was a little more active and had finished the course of radiotherapy. On 31 October, he discussed whether it would be possible for him to be released on compassionate grounds because of his cancer diagnosis. The Head of Healthcare told the investigator that no

application had ever been made as hospital doctors were not able to confirm he had less than three months to live, which is part of the usual criteria for compassionate release.

45. Each time a prisoner leaves prison for a hospital appointment (or other reason) a risk assessment is completed to determine the level of security required. The man was originally a category C prisoner and routinely escorted by two officers and handcuffed to one of them.
46. During the first week of November 2011, the man was re-categorised to category D the lowest security level. He had expected this would mean that he would no longer be handcuffed to an officer when he went to hospital. However, on 8 November, when he had a hospital appointment, staff in the security department decided that he would be handcuffed as usual. He refused and as a result was not allowed to leave the prison to attend the appointment. He complained about this and one of the security managers replied to say:

"Staff work off a risk assessment completed prior to the escort...the cuffing arrangements are on that assessment. I understand that you are a Cat D prisoner but we are bound by the rules imposed on us as a Cat B establishment."
47. In November, the man applied for release on temporary licence which he hoped would enable him to attend hospital without an escort. This was not allowed as he had not been tested in open conditions and had only recently been re-categorised.
48. On 30 November, a prison doctor reviewed the man and his treatment. He was being given injections of hormones every 12 weeks for the prostate cancer and the next one was due in January 2012. The doctor noted that he felt okay and that his pain was controlled to the point that he did not need to take oramorph.
49. Two weeks later, the man's right leg began to swell and blood tests were carried out. After consulting with a hospital specialist, one of the doctors, prescribed enoxaparin, a medication to prevent blood clotting. His prescription for warfarin had stopped in October but the doctor re-started it. The doctor requested an ultrasound examination at the DVT clinic.
50. On 15 December, the man attended a pre-operative clinic at a local hospital. The risk assessment form for this visit is rather unclear, with many alterations. It appears that the original decision was that he should be restrained by an escort chain (a long chain with a handcuff at each end attached to the prisoner and an officer) but this was changed later when it was noted that he was a category D prisoner and no restraints were necessary.
51. The man was due to have an operation, on 5 January, to relieve a blocked catheter. Healthcare staff liaised with hospital staff about preparations for the operation, including the need for potassium supplements and for warfarin to

stop five days before the planned surgery. One of the healthcare staff wrote in his case notes that because the hospital doctor had told him the date of the operation, the date would perhaps have to be changed. His partner told the investigator that they were told that the operation had been cancelled because the prison had information that he was going to escape. The Assistant Director of Security and Operations said that the security department did not have the authority to postpone or cancel a prisoner's operation and if necessary the prison would arrange appropriate security. There is no other information in the records to explain why the operation was cancelled.

52. The man had an ultrasound scan of his leg on 20 December, at the local hospital. The risk assessment form for this visit stated, "Numerous escorts without incident. Cat D status so no restraints required".
53. On Christmas Day, hospital staff faxed the healthcare department telling them to stop the man's enoxaparin but to continue the warfarin. On 29 December, a nurse examined him after he complained of pain in his thigh and redness in the lower leg. The nurse noted that the lower leg appeared inflamed. A different nurse assessed him later in the day and questioned whether the DVT was spreading. She also noted a problem with obtaining a blood sample. This was discussed with hospital staff, who advised restarting the enoxaparin in addition to the warfarin. He refused to give blood for an INR reading.
54. On 3 January 2012, the man again refused to have blood taken but agreed to a finger prick test. His INR score was low and the doctor increased his dosage of warfarin. Two days later, the day he was originally expected to have his operation, a nurse examined his leg and noted his thigh was swollen and hard. A doctor then increased the dosage of enoxaparin.
55. On 10 January, the man refused to have blood taken for an INR reading. He told the nurse that they were not caring for him properly as he had not received his next chemotherapy injection. However, the injection was not due until 23 January.
56. The next day, the man refused to see a nurse, for a spirometry test (to measure how well a person is breathing) which he said he could not manage. At his request he saw a doctor and told him that he felt sick, was increasingly short of breath and that his ability to walk had deteriorated a lot over the previous three days. The doctor noted that the DVT had progressed even while he was taking warfarin and it was very difficult to get blood from him. He thought the man might be suffering from a blood clot on the lung and arranged an emergency admission to hospital.
57. A few days later hospital staff told prison healthcare staff that the man was being treated for cellulitis (an infection in the deeper layers of the skin) with intravenous antibiotics. His condition deteriorated significantly and he was moved to the hospital's high dependency unit where his partner, mother and sister-in-law were able to be at his bedside. Prison managers began the

process of applying for release on compassionate grounds. He was given a blood transfusion but his condition continued to deteriorate and he died.

58. The prison family liaison officer arrived at the hospital shortly before the man's death and spoke to his family. After his death, the prison offered support and assistance with the funeral. His friends on the wing held a collection in his memory and raised £185.

## ISSUES

### Clinical care

59. When the man arrived in prison, his health conditions were noted as type II diabetes, morbid obesity and asthma. During his time in prison, he was prescribed a range of medications (the clinical reviewer lists 29 different drugs in his report). He died as a result of a retroperitoneal haemorrhage. He had developed a renal cyst which subsequently ruptured and, as his blood had been thinned by the warfarin, the cyst bled into the cavity around the kidney and peritoneum (a membrane which helps support the organs).
60. The clinical reviewer said that the man had frequent access to GPs and nurses and, in spite of his dissatisfaction, the standard of care was generally appropriate. He concludes that his nursing care was equivalent to what he might have received in the community.

“The man died of a rare side effect of warfarin therapy - and this may have happened whether he was a prisoner, or an NHS patient being treated in the community.”

However, he also highlights some deficiencies in the man's care, including the delay in referral to secondary care and cancellation of a date for cancer surgery. He also points out that as he had been prescribed warfarin, it was important for him to have regular tests of how quickly his blood clotted. This had not been done in the three weeks leading up to his final admission to hospital.

### *Delay in referral*

61. The clinical reviewer considers that the man was not referred to secondary care as early as he could have been. The blood in his urine was a 'red-flag' sign that should have warranted an urgent referral to exclude the possibility of cancer. On 1 February 2011, when he reported symptoms of stinging on passing urine and blood, it was appropriate, in the clinical reviewer's opinion, to try antibiotics, but he says that most GPs would consider referral to a hospital specialist when there is unexplained blood present in the urine.
62. When the man told the doctor he had blood in his urine, the doctor sent a sample for tests to see if the cause was a urinary infection. There is no result in the medical record from the urine sample sent on this day. A sample was not received at the hospital until 22 March 2011 and this was too old to test. The first urine test result in the medical record was from a sample collected on 20 April 2011. This did not indicate infection but showed a high number of red blood cells - consistent with testing positive for blood using dipstix, a different testing method.
63. Blood test results on 1 March 2011, showed a drop in renal function and, compared to the results of blood tests in the records from 2008, was an indication of renal damage. This also indicated that this was not a simple

urinary infection. The GPs planned to act on the results of the urine tests, but did not receive a valid result until 21 April 2011 and did not refer the man to a specialist until 24 May. The clinical reviewer set out the seriousness of this delay:

“Frank haematuria, or blood in the urine, is a red-flag sign and the NHS ‘map of medicine’ recommends that ‘visible haematuria in all instances warrants urgent referral to exclude urological malignancy.’

64. We agree that doctors should have made an earlier referral and make the following recommendation based on that of the clinical reviewer:

**The Head of Healthcare should ensure that doctors refer prisoners urgently to secondary care when there are concerning signs of haematuria.**

#### *Cancellation/postponement of the man’s operation*

65. According to the medical records, the man’s operation to address his blocked catheter, scheduled for 5 January 2012, was cancelled for security reasons as his doctor had told him the date. However, the Head of the Security Department told the investigator that his staff would not do so. He maintained that the security staff would have assessed the level of security needed and made arrangements accordingly.
66. The Prison Service’s National Security Framework, which governs prisons’ security arrangements, does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that this is often the case. The entry in the man’s medical record suggests that there was an assumption that this would be changed. The national security guidance expects that the prisoner’s condition and the urgency of the treatment required should be taken into account when taking a decision. We accept that Lowdham Grange says that this would not have happened, but there is no other recorded reason to explain why the appointment was cancelled.

**The Director and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner’s health.**

#### *Warfarin therapy plan*

67. The man twice developed DVTs. The clinical reviewer concludes that the first was treated appropriately and medication stopped in October as planned. The second DVT was suspected on 12 December 2011 and, after consulting hospital staff, treated with enoxaparin (an anti-clotting medicine) and warfarin. However, it was difficult to take blood from him and he sometimes refused to allow staff to try. Prisoners have the right to consent to or refuse treatment,

and when he refused to have blood taken, he was entitled to do so. There was no reason to doubt his mental capacity.

68. The last recorded blood test was on 4 October 2011, but the man agreed to a finger prick test on 3 January 2012. The results showed a low INR score so his warfarin was increased. He also continued to have enoxaparin injections to supplement the warfarin. The clinical reviewer states that the injections would have stopped once the INR score was acceptable.
69. The man continued to have enoxaparin injections until he went into hospital on 11 January. It is possible that, without a recent blood test to give an accurate INR, there was an accidental overdose of warfarin, but without the INR score this question cannot be answered.
70. The clinical reviewer goes on to say that even if the planned operation on 5 January had gone ahead and the warfarin had been stopped, 'he could still have had the same fatal haemorrhage at another time during the course of his anticoagulant therapy'. We make the following recommendation:

**The Head of Healthcare should ensure that there is a robust plan in place for when staff have difficulty obtaining blood samples and that prisoners with needle phobia are helped to develop coping strategies.**

*Waiting times to see a doctor/nurse practitioner*

71. We are concerned that even when the man was in pain and his appointment was prioritised in May 2011, it took eleven days for him to see the doctor. In the first half of 2011, prisoners at Lowdham Grange waited an average of six weeks for a routine appointment with a doctor. This was a matter of great concern to prisoners and prison staff. The new Head of Healthcare arrived in May 2011 and conducted a full review of the process and introduced changes which, combined with improved staffing levels, reduced the waiting time. At the time we interviewed the Head of Healthcare in May 2012, the waiting time for a routine appointment was seven days and there were arrangements for patients to be seen much quicker if it was urgent.
72. Serco healthcare employs GPs from a local GP practice and runs three three-hour doctor clinics a week. In addition, there are two three-hour clinics each week staffed by an advanced practitioner nurse (APN) who can prescribe a range of medications. Each clinic caters for 12 appointments. The Head of Healthcare was intending to employ an additional advanced practitioner nurse to manage the triage process of deciding the urgency of the patients' symptoms and the most appropriate referral. We are pleased to hear that improvements have been made in the waiting times to see doctors and it is important that these are maintained. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners have appropriate access to GPs for both routine and urgent appointments and should conduct regular audits of waiting times to ensure a satisfactory**

**standard of service is maintained.**

### **Use of restraints**

73. 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 also takes into account factors such as the prisoner's health and mobility.
74. 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.
75. For the appointment on 8 November, security staff completed the risk assessment on 1 November, a full week before the man's visit to the hospital. When the risk assessment was completed, he was a category C prisoner but shortly afterwards, he was re-categorised to D. The assessment was therefore based on out-dated information. The security manager said that the assessments had to be completed "...on a very current basis; it has to be very up to date". Clearly, in this case it was not. In any event the security category alone should not determine the level of restraints.
76. The man was very upset when staff told him that he would be handcuffed to officers and refused to wear the handcuffs. Staff did not allow him to leave the prison and he missed his appointment. He then complained through the prison's complaints procedures. The reply said that because the prison was a category B prison, they are constrained by, "the rules imposed on us as a Cat B establishment". Although later, restraints were not used, we are concerned that the risk assessments were not based on his individual circumstances. We are not satisfied that his risk was appropriately assessed in line with the guidance in the High Court Judgement.

**The Director 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 Head of Healthcare should ensure that doctors refer prisoners urgently to secondary care when there are concerning signs of haematuria.
2. The Director and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.
3. The Head of Healthcare should ensure that there is a robust plan in place for when staff have difficulty obtaining blood samples and that prisoners with needle phobia are helped to develop coping strategies.
4. The Head of Healthcare should ensure that prisoners have appropriate access to GPs for both routine and urgent appointments and should conduct regular audits of waiting times to ensure a satisfactory standard of service is maintained.
5. The Director 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.

## ACTION PLAN: The Man – HMP Lowdham Grange

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that doctors refer prisoners urgently to secondary care when there are concerning signs of haematuria.	Accepted	<p>The Head of Healthcare has successfully implemented clinical training for all staff with regards to the management of patients presenting with haematuria.</p> <p>This training is a continual rolling package which available for all nursing staff.</p> <p>In addition to this patients presenting with these symptoms are referred using the NHS urgent 2 week wait referral system.</p> <p>A referral is completed electronically and forward to the receiving acute hospital trust, these referrals are tracked by the administration team within the healthcare department to ensure of its completion. The referrals are maintained through a tracker database in additional all referral are kept on patients individual care records (System1)</p> <p>The routine referrals as per NHS standards are 18 week</p>	<b>Completed</b>	
2	The Director and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there	Accepted	<p>In any case where it deemed unavoidably necessary to cancel and/or postpone a prisoner's hospital appointment, the Duty Senior Manager in conjunction with the Head of Healthcare will make this decision collaboratively and then the Duty Senior Manager will ensure the agreed decision will</p>	<b>12.07.2013</b>	

	is no detriment to the prisoner's health.		<p>be annotated on the prisoners risk assessment documentation.</p> <p>A notice to all Operational Senior Managers and Reception staff will be published to enforce this practice</p>		
3	The Head of Healthcare should ensure that there is a robust plan in place for when staff have difficulty obtaining blood samples and that prisoners with needle phobia are helped to develop coping strategies.	Not Accepted	<p>All prisoners are sympathetically supported through any anxiety during any treatment processes undertaken by the healthcare department, including phlebotomy.</p> <p>The Healthcare department in 2012 purchased a blood sampling machine which allowed nursing staff to take a blood test for coagulation from a pin prick test. This was to allow an alternative to patients who had specific needle phobias. This however is not a definitive (INR) but allows staff to have a guidance of blood coagulation for patients who are receiving warfarin treatment.</p> <p>As clinicians and nurses we always support patients through stressful periods by supportive talking and encouraging with the upmost intent to support these individuals through periods of stress and anxiety. There's is no specific training or clinics that are provided (as mirrored in the community)</p>		
4	The Head of Healthcare should ensure that prisoners have appropriate access to	Accepted	All Healthcare clinical waiting times are monitored and reported on to the customer and the MOJ controller on a monthly basis. Clinical	<b>Completed</b>	

	GPs for both routine and urgent appointments and should conduct regular audits of waiting times to ensure a satisfactory standard of service is maintained.		waiting times are in line with the community setting and we keep emergency/urgent appointments on every clinical day for GP/ANP services. These statistics were effective from July 2011 and are shared with the Senior Management team, the IMB, the MoJ Controller and are reported/ discussed in the monthly Senior Management Team meeting Service Level Agreement meetings		
5	The Director 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	The Director will ensure that all prisoner escorts will be risked assessed in line with Local Security Strategy Instruction 2 – 09 where it states the assessment will consider the following;; <ul style="list-style-type: none"> <li>• The prisoners medical condition</li> <li>• The prisoners security category</li> <li>• The nature of the prisoners offending history, including previous escape</li> <li>• The risk to the public and hospital staff, including the risk of hostage taking</li> <li>• The prisoners motivation to escape</li> <li>• The likelihood of outside assistance to escape</li> <li>• Any intelligence received concerning escort risk</li> <li>• The prisoners conduct while in custody</li> <li>• The physical security of the venue.</li> </ul> Risk Assessments will only be approved by the Assistant Director of Security of Operations and in his/her absence the Deputy Director/ Director. At weekends the Duty Senior Manager in charge of the establishment will	<b>12.07.2013</b>	

			<p>make this decision in the absence of the Assistant Director of Security and Operations.</p> <p>A reminder will be published to all Operational Duty Senior Managers and Duty Managers that in the event of any late changes to a prisoners individual circumstance the Assistant Director must always be consulted, and in their absence the Deputy Director/ Director.</p>		
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