PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in a hospice in March 2013, while a prisoner at HMP Wandsworth

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 investigation report into the death of a man at a hospice in March 2013 while in the custody of HMP Wandsworth. He died as a result of pancreatic cancer. He was 45 years old. I offer my condolences to his family and friends.

A clinical review was conducted into the clinical care the man received at Wandsworth. Wandsworth prison cooperated with the investigation.

The man had been in prison custody since March 2010 and moved to HMP Wandsworth the next month. In July 2011, he was diagnosed with pancreatic cancer which was treated palliatively as no cure was possible. He did not want to die in prison and he applied twice for compassionate release, but both were rejected. In February 2013 he was moved to a hospice where he died just over a month later.

The clinical review identified some areas for improvement in healthcare services but concluded that the man's clinical care was equivalent to that he might have expected to receive in the community. I am concerned that the use of restraints when he attended hospital was not always justified by a properly considered risk assessment and it is very difficult to see how their use when he moved to a hospice at the end of his life could be regarded as humane. However, overall I consider that he received a satisfactory standard of care from prison and healthcare staff in relation to his illness.

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 to HMP Brixton in March 2010, and moved to HMP Wandsworth in April. In August 2010, he was convicted of a serious sexual offence and sentenced to 8 years imprisonment and remained at Wandsworth.

2. On 23 June 2011, the man began to experience abdominal pain, and he was admitted to hospital as an emergency on 26 June. He was diagnosed with advanced pancreatic cancer which was considered inoperable. He was offered chemotherapy and radiotherapy as palliative treatment. He wanted to stay for as long as possible in a residential unit with his friends, which he was mostly able to do apart from brief spells in the prison's high dependency unit to help manage his pain and later when he was no longer able to care for himself.

3. The man's management and care were discussed at weekly staff multi-disciplinary meetings for prisoners with complex issues. In September 2011, a family liaison officer was appointed to keep his partner, his son and other family members informed of his condition. Two applications for compassionate release were appropriately considered but declined on grounds of risk. He attended hospital for appointments and in-patient stays on a number of occasions after his terminal diagnosis at each time restraints were used.

4. The man did not want to die in prison. Healthcare staff tried to find a hospice bed and through regular, effective liaison with a hospice, arrangements were made for him to move there on 5 February 2013.

5. In March the man died at the hospice. A post-mortem examination was not carried out as the Coroner was satisfied that he died of metastatic pancreatic cancer.

6. We are satisfied that the man received a good standard of care at Wandsworth. Both he and his family were kept fully informed of his diagnosis and treatment. However, we make recommendations about managing appointments, the management of low potassium levels and the need for risk assessments for escorts to take full account of how health issues impact on risk.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 7 March 2013. The investigator issued notices to staff and prisoners at HMP Wandsworth to inform them of the investigation and asking anyone with relevant information to contact her. One prisoner asked to meet her.

8. The investigator visited Wandsworth on 12 March and met members of the prison management team, staff involved in the man's care and a member of the Independent Monitoring Board. She also visited C wing, where he had lived until his health deteriorated, and the Jones Unit (a high dependency unit for in-patients).

9. The investigator obtained copies of the man's medical record and relevant prison records. The local PCT appointed a clinical reviewer to review the medical care he received at Wandsworth. He was also given a copy of his medical record.

10. The investigator interviewed staff at Wandsworth in May. She also spoke by telephone to the prisoner who had earlier asked to meet her, as he had transferred to another prison. After the interviews, she gave written feedback to the Governor about the preliminary findings of the investigation.

11. HM Coroner for Inner West London was informed of the investigation. The Coroner did not require a post-mortem as the man's death was not unexpected. We have sent a copy of this investigation report to the Coroner.

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to identify relevant matters which they wished the investigation to consider. His family were concerned about delays he had experienced in receiving his medication, whether incorrect medication had been given, why compassionate release had been denied, interaction between him and staff, missing property, and difficulties they had experienced in contacting Wandsworth's family liaison officer and about him being handcuffed while receiving treatment in hospital.

13. 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 WANDSWORTH

14. HMP Wandsworth is one of the largest prisons in the United Kingdom. It normally holds up to 1,665 unconvicted and convicted adult men. Its current capacity is reduced to 1,284 as the Onslow Centre for vulnerable prisoners, is closed for refurbishment. As a temporary measure, C wing now takes a small proportion of vulnerable prisoners. Wandsworth's catchment area serves the courts of central and south west London as well as the Home Counties.

15. At the time of the man's death, healthcare services at Wandsworth were commissioned by the local Primary Care Trust. Following NHS reorganisation, the commissioner is now NHS England London Region. The Jones Unit is a six-bedded in-patient facility for patients needing more frequent observation and higher input than the healthcare centre is able to provide. There are a number of nurse-led clinics and doctors, dentists and other specialists run regular clinics at the prison.

HM Inspectorate of Prisons

16. HM Inspectorate of Prison's (HMIP) most recent inspection of Wandsworth was in June 2013 but the report is not yet published. In HMIP's last inspection report of June 2011, it noted that health services were satisfactory on the whole and the prison had made progress from previous inspections, albeit slowly. Prisoners were critical about access to and communication with health services staff and the most recent review of prisoners' health needs had been in 2008. Prisoners told HMIP that the routines for primary healthcare delivery and medicine administration did not allow for sufficient time for prisoners with additional healthcare needs. The Jones Unit for in-patients with physical illnesses was described as excellent with facilities of a high standard and all rooms well equipped for the management and care of patients.

Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure proper standards of care and decency.

18. In their latest published annual report, the IMB reported that there had been a high number of incidents involving missing medication and the prescribing or administration of drugs. Staff shortages in healthcare had led to a high dependency on agency staff. However, the rate of complaints had reduced by three-quarters by May 2012 and the IMB believed that staff were attempting to address prisoners' health issues as they arose.

19. The IMB report also highlighted problems with property, particularly affecting prisoners who had been transferred to other prisons whose stored property had been left behind at Wandsworth.

Previous deaths at Wandsworth

20. This office has investigated seven deaths at Wandsworth through natural causes in the last three years. In previous reports issued in the last year we have been concerned that restraints were used for hospital visits without an appropriate risk assessment, an issue we identify again in this report.

ISSUES

The diagnosis of the man's terminal illness

21. On 20 March 2010, the man moved from HMP Brixton to HMP Wandsworth. The records show no significant health concerns about him at this time, although he had a history of drugs misuse, depression, foot pain and food allergies.

22. The man had very little interaction with healthcare staff until 23 June 2011, when he saw a prison GP complaining of abdominal pain. A doctor reviewed him again the next day and arranged urgent blood tests after noting that he looked jaundiced and was excreting dark urine. The blood tests confirmed that he had jaundice and abnormal liver function. He was admitted to hospital on 26 June as an emergency, due to his acute symptoms.

23. The man remained at hospital until 12 July. The cause of his jaundice was diagnosed as a large ampullary tumour. (The Ampoulla of Vater is where the bile duct and the pancreatic duct meet. A tumour at that location will affect bile drainage from the liver and lead to jaundice.) A stent was inserted in his intestine to relieve the blockage caused by the tumour, which was confirmed as a carcinoma (cancer).

24. We are satisfied that the man was appropriately referred to the hospital and that the diagnosis of cancer was not delayed.

Informing the man about his condition and treatment

25. When the man returned to the prison on 12 July, he was very anxious about his condition. He told a nurse that he was going to be transferred to another hospital for treatment and that the diagnosis was unclear. She contacted the hospital to obtain a copy of his discharge letter which was faxed to the prison on 15 July. The letter gave a diagnosis of ampullary carcinoma (a pancreatic cancer). It is not clear from the record when he was first told that he had pancreatic cancer and by whom.

26. On 16 August, the man went to another hospital to discuss the possibility of surgical treatment for his tumour. He was told that it was inoperable and returned to the prison tearful, distressed and overwhelmed. A mental health nurse offered him support and guidance. He was reviewed frequently and offered psychological support and counselling. On 12 September, he was referred to a hospice for palliative care and counselling.

27. On 13 September, the man attended an appointment at the hospital's oncology clinic. He agreed to palliative chemotherapy which would ease his symptoms but not provide a cure. This would involve weekly visits to the hospital for intravenous medication and oral medication to take at Wandsworth. On 20 September, a consultant oncologist wrote to a senior sister at Wandsworth to confirm that he had advanced cancer which was unsuitable for surgery and that his prognosis was months rather than years,

although his response to treatment might affect this. At a chemotherapy session on 22 September, he was given an advice sheet by the hospital on managing his health while on chemotherapy. A nurse discussed with him what his treatment was likely to involve and what the side effects might be.

28. The man continued chemotherapy into 2012. On 22 June 2012, a consultant clinical oncologist at the hospital informed him that his tumour had grown too large and was not curable. She explained that palliative radiotherapy could be used to control his symptoms and possibly the size of the tumour and he agreed to have the treatment. He subsequently received high dose palliative radiotherapy at the end of July and completed the course on 1 August.

29. On 10 August, when the man completed radiotherapy, the oncology team explained that it was too early to know whether the treatment had been of benefit. He was told again that his illness was not curable and his life expectancy would be in months rather than years.

30. It seems that the man was informed that he had cancer by hospital staff when it was first diagnosed, although it has not been possible to verify this. We are satisfied that prison healthcare staff made efforts to get the relevant information from the hospital to ensure that he was appropriately informed. After the initial diagnosis, he was kept well informed about his condition and treatment options.

The man's medical appointments and treatment

31. The man was discharged from hospital on 12 July, with a plan to arrange a Positron Emission Tomography (PET) scan at another hospital (this gives a three-dimensional view of the tumour and how the body tissues are working). The scan was due to be arranged through an organisation that provides specialist tests for the NHS. There appears to have been some difficulty in arranging this.

32. On 2 September, a consultant hepatologist at the hospital wrote to the prison expressing his concern that the organisation had been trying to contact the prison to make arrangements for a PET scan but said they had not received replies to telephone calls, voicemail messages or faxes. There is nothing in the records to show any contact by the organisation and we have been unable to find what happened.

33. A PET scan was eventually arranged for 30 September. However the man did not attend due to a "mix up concerning his paperwork in security". A further appointment was made for 3 May 2012, but this was cancelled because the scanner was not working.

34. After this, there are entries in the records on 22 June and 12 July by a nurse stating that she would ask healthcare administrators to chase up the PET scan. We have been unable to find any evidence that the man ever had a PET scan, although it is likely that the need for this was overtaken by his declining health.

35. The man had a number of appointments with the oncology department after his diagnosis and be began palliative chemotherapy.

36. On 10 February 2012, the man was due an appointment at the oncology clinic as part of his ongoing treatment. Although the documentation was prepared, he was unable to attend as he was missed from the staff escorts notification list. The appointment was rescheduled to 20 February but he was suffering from nausea that day and felt too ill to attend. On 22 February, the appointment went ahead.

37. On 2 June, the man was found to have severe hypokalemia (where potassium levels are well below normal). Hypokalemia can be a life threatening condition. He was encouraged to take oral fluids as he was unable to keep his food down. The clinical reviewer points out that the hypokalemia was due to a prolonged period of vomiting and was unlikely to have been corrected with oral supplements. He should have been referred to hospital as an emergency.

38. On 4 September, the man was taken to the accident and emergency department of the hospital with a recurrence of jaundice. He refused to be admitted and discharged himself against medical advice. However, on 10 September, he was admitted and had a percutaneous transhepatic angiogram (a procedure to identify blockages in the liver or bile duct). He was fitted with another stent to relieve the obstruction causing the jaundice and returned to Wandsworth on 18 September.

39. On 30 September, the man developed severe chest pain. He was assessed by a Senior Sister, who arranged for him to be taken by ambulance to hospital. He was treated in hospital for tachycardia (rapid heartbeat). He returned to Wandsworth on 1 October.

40. The man spent between 2-18 December in hospital due to vomiting blood. While in hospital, he had a massive gastrointestinal haemorrhage which required several blood transfusions. He also became septic and required treatment with intravenous antibiotics.

41. The man was again admitted to hospital on 3 January 2013, where it was found he had a liver abscess. This was treated and he returned to Wandsworth on 22 January.

42. The man was mostly appropriately referred to hospital and was able to attend most of his appointments. However he missed two important appointments, one for a PET scan and another for chemotherapy because of errors at the prison. He should also have been taken to hospital in June 2012 when he had severe hypokalemia.

The Governor and Head of Healthcare should ensure that all requests for follow up appointments are properly recorded and that

administrative and security procedures do not delay or prevent prisoners attending important hospital appointments.

The Head of Healthcare should ensure that prisoners with severe hypokalemia are referred urgently to hospital.

The man's pain relief and medication

43. The man was prescribed oxycodone (a synthetic opiate used to relieve moderate to severe pain) and paracetamol when he left hospital in July 2011. He complained on several occasions that his pain was not well controlled. In August 2011, a nurse noted that he was frustrated about his treatment regime and that he had to wait too long at night for his pain relief medication. He was not allowed to keep his medication in his possession as it was an opiate. His dose of oxycodone was increased and he asked whether he could keep some in his cell to take if he had pain at night. Wandsworth's lead GP advised that his medication should not be increased any further at that time, cautioning that he had a history of drug dependency.

44. A Senior Sister had asked the man to consider moving to the Jones Unit where he would be able to obtain pain relief more quickly. However, he did not want to move from the wing, because he wanted to be near his friends.

45. At 2.05am on 12 September 2011, the man asked an officer to contact a nurse as he was in pain. A nurse saw him at 2.20am and gave him medication. He told her that he would make a complaint because he had been in pain for three hours. She wrote in his clinical record that she explained to him she had received the call from the officer at 2.05am and had to wait to be escorted to the wing by the night manager as she did not carry keys. Later that day, he met a nurse from the mental health team and complained about having to wait for medication. On 15 September, he saw the complex cases team and said that although his day time pain was under control, at night he did not think his pain was well managed. The matter was discussed and it was suggested that he should move to the Jones Unit at night and return to his usual cell during the day. He said he would consider this.

46. A prisoner who lived on C wing at the same time as the man told the investigator that one night he heard him tell the night officer that he was in pain. He said a nurse had arrived, pushed two paracetamol tablets under his cell door and told him to "deal with it". He said he had witnessed a similar incident a few weeks before the man died when he had been in a lot of pain and a nurse gave him two paracetamol tablets when he needed stronger medication. We have not been able to verify this account. In addition to his other pain medication, he was prescribed six paracetamol a day, two of which were to be taken at night.

47. On 28 September 2011, a doctor told the man that if he needed more pain relief then it needed to be managed on the Jones Unit which had qualified

staff who were available 24 hours. However, he refused to be admitted to the Jones Unit at that time.

48. In September, staff from a hospice met the man, a Senior Sister and a nurse to formulate a pain management plan. They also agreed to have a counselling session every two weeks.

49. The man was admitted to the Jones Unit (so that his pain could be managed) on 25 February and 25 May 2012. On 30 March, he was mistakenly given a 5ml dose of calamine lotion instead of Gaviscon by a healthcare assistant. His clinical record shows on 6 June that he was angry at being in pain and the Jones Unit was waiting for his medication to be delivered from the hospital. He asked to taken to hospital as he did not feel his treatment was being well managed at Wandsworth. A nurse spoke to a doctor from the hospice, who agreed that he would benefit from an in-patient stay at the hospital to manage his pain. He was given a fentanyl patch (a fast acting and strong synthetic opioid used to treat severe pain) and his dose of oxycodone was increased.

50. The man was admitted to hospital for pain relief from 7-18 June 2012. Further medical investigation showed that his tumour had grown, causing a partial obstruction of his duodenum. To alleviate his discomfort, he had a stent inserted so that he could eat and was given softer foods.

51. In July, the man continued to lose weight and experienced numbness in his left leg. His appetite was poor and his sleep pattern disrupted. The Senior Sister described him as expressing feelings of apathy and anger. He was prescribed lorazepam for anxiety and zopiclone to help him to sleep.

52. On 7 November, the man told a nurse he felt his pain relief was becoming less effective and he was experiencing back pain but he would discuss it with a doctor from the hospice when he next visited. The doctor visited him on 19 November and increased his fentanyl patch dose.

53. The man was an in-patient at the hospital from 3 - 22 January 2013, after being admitted with a fever. He was found to have a liver abscess and was treated with antibiotics.

54. The man's condition deteriorated further and he was admitted to the hospice on 5 February. He died at the hospice in March.

55. The clinical reviewer notes that the man often said that his pain was not adequately controlled. He says this must be taken in the context of the daily requirement for pain control over a prolonged period of over 18 months. His complaints often related to him not being able to access pain relief during the night and delays in receiving pain relief during the day. The clinical reviewer says this was partly because he refused to move to the Jones Unit where his need for pain relief could be more closely monitored and addressed and that it was not possible to provide the same access to pain relief on the wing.

56. Although the accounts would suggest that pain control was not always optimal, we accept the view of the clinical reviewer that overall the approach to pain management was of the standard expected. There was close liaison and specialist advice from the palliative care team at the hospice and the hospital to help ensure that the man's pain was managed as effectively as possible.

Liaison with the man's family

57. In September 2011, a manager at Wandsworth was appointed the man's family liaison officer (FLO). Initially they met monthly and he discussed his role with the man, who said he had a number of family members he wished to nominate as his next of kin. He asked whether his family would be able to be with him during chemotherapy appointments. The FLO discussed this with the security department and arrangements were made for his partner to join him. He was given the date of his appointments in advance so he could arrange for a family member to attend. (Usually, prisoners are not given prior notification of hospital appointments for security reasons).

58. Due to staff movements, another member of staff took over as the prison family liaison officer in December 2012. She ensured that family members were updated about the man's condition and that they were able to visit him in the hospice when he moved there at the beginning of February 2013.

59. The FLO moved to another prison just after the man's death but continued her role as family liaison officer as she had already established links with his family. She assisted with the funeral arrangements and in line with national policy, Wandsworth offered assistance with the funeral costs.

60. The man's family told us that after his death they had great difficulty in contacting the FLO. She told us that she had informed his family about her move and had given them her new telephone number

61. Wandsworth appointed a family liaison officer at an appropriate stage and we are satisfied that the man and his family were kept well informed and were appropriately supported throughout his illness. We also understand that Wandsworth had appointed a new family liaison officer before the FLO left, but members of his family said they were unaware of this. After she moved to another London prison she also continued as family liaison officer to provide continuity of care which demonstrates some commitment to her role. However, there appears to have been an unfortunate breakdown in communication which left some family members frustrated with the inability of Wandsworth to deal effectively with their concerns. In addition to the confusion about family liaison contact the prison was unable to find records relating to the man's belongings to ensure that all his property was returned appropriately. This echoes the concerns expressed in the IMB report about the handling of prisoners' property at the prison.

The Governor should ensure that bereaved families have a clearly identified liaison officer at the prison who ensures that deceased

prisoners' property is properly recorded and stored and returned to their families as soon as possible.

The man's location

62. The man lived in the Onslow Centre, the unit for vulnerable prisoners at Wandsworth until it closed in March 2012 for refurbishment. He then moved to C wing which was staffed by former Onslow Centre staff.

63. He had been asked several times to consider moving to the Jones Unit which is a small high dependency unit with six beds and individual rooms and has nursing support 24 hours a day. He consistently declined to move to Jones as he wanted to stay with his friends on a much larger wing. However he had several short stays on the unit to manage his pain.

64. The man moved permanently to the Jones Unit on 29 January 2013 when he was unable to care for himself and needed constant nursing care.

65. We are satisfied that the man was appropriately located during his illness. It was his decision to remain on an ordinary wing for as long as possible so that he could be with his friends. Regrettably, the Jones Unit was not suitable to allow visits from other prisoners. On C wing, staff left his cell unlocked as often as possible so he could enjoy the company of his friends. The prison enabled him to spend time with others on his wing for as long as possible while encouraging him to move to the Jones Unit when the management of his pain became difficult.

Compassionate release

66. Early release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 – Parole, Release and Recall. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS). A decision to release someone early is rare.

67. The man made two applications for compassionate release, in April 2012 and February 2013. Both were turned down on behalf of the Secretary of State for Justice on the basis that the man's risk to the public was still considered too high. We have examined carefully the handling of the applications which went from the prison to the Public Protection Casework Section of NOMS and we are satisfied that both applications were appropriately progressed by Wandsworth and received appropriate consideration. Unfortunately for him

his applications were rejected but we note that he spent the last month of his life in a hospice rather than prison, albeit while technically still in prison custody.

Palliative care plans and end of life pathway

68. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients makes choices about how they are cared for towards the end of their lives.

69. The man was referred to the palliative care team at the hospice on 12 September 2011. Staff from the hospice met frequently with him and healthcare staff at Wandsworth. We agree with the clinical reviewer, that the team from the hospice were involved at an appropriate stage and at an appropriate level. Communication between Wandsworth, the palliative care team and the man's care was of an expected standard and included multi-disciplinary meetings, planned care and written communication of changes to medication.

70. Because of the distressing nature of his illness, it is also important to note that the man received psychological support from the mental health team and other staff at Wandsworth.

Restraints, security and bed watch

71. 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, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

72. 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.

73. After the man was told that his illness was terminal, he was escorted to hospital many times for out-patient chemotherapy and radiotherapy appointments and was admitted six times as an in-patient. The prison has

been unable to find and supply copies of the risk assessments for these visits, but we note in the escort records that he was restrained on each occasion. Without the records we are unable to say whether these risk assessments properly took account of his medical condition at the time or whether the fact he was receiving chemotherapy and other life saving treatments had been noted.

74. The man was taken to hospital on 4 September 2012 with jaundice. However, he refused to be admitted and discharged himself against medical advice. He explained to a Sister the next day that he was in the accident and emergency department, handcuffed and in pain and was only given co-codamol. He found the experience distressing and undignified.

75. On 4 December 2012 when the man was an in-patient at hospital, the escorting officers contacted the prison for permission to remove his escort chain at the request of the duty registrar as he was critically ill and needed a number of blood transfusions. The escort chain was removed and re-applied at 5.15am based on the duty governor's "discussions with the registrar and observations from bedwatch staff". This was despite the duty governor's written comment in the Family Liaison Log that "next 24hr prognosis is said to be poor as he requires constant blood transfusions to keep him stabilised".

76. When the man was taken to the hospice by taxi on 5 February 2013, in the last weeks of his life, he was accompanied by two officers and a nurse. His escort risk assessment described his risk to the public as high, risk of hostage taking; escape potential and likelihood of outside assistance as medium. He was double cuffed (double cuffing entails the prisoner having his hands cuffed in front of him then having one wrist attached to one prison officer by an additional set of handcuffs.) Next to the box which said "can restraints be removed for emergencies" 'no' was circled with "seek advice from the duty governor if necessary". Once in the hospice, he was restrained with an escort chain (which is a metal chain approximately 2 metres long with a handcuff at each end. One handcuff is attached to the prisoner and the other to an escorting prison officer). He remained restrained by an escort chain until two days later on 7 February when the risk assessment was reviewed. It was then decided to remove them "due to current serious ill health".

77. We are concerned that the man was restrained while seriously ill in hospital following a gastrointestinal haemorrhage and numerous blood transfusions, despite it being noted by the duty governor that his prognosis was poor. He was also restrained while receiving chemotherapy. It is very difficult to see how the use of double cuffs was justified when he was being escorted to the hospice where he was going to die. It is also unacceptable that he remained in restraints at the hospice for two more days before a review took place.

The Governor should ensure that the use of restraints for hospital and hospice escorts accurately reflects the prisoner's actual risk at the time, balancing both security and health, and is kept under frequent review.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all requests for follow up appointments are properly recorded and that administrative and security procedures do not delay or prevent prisoners attending important hospital appointments.

2. The Head of Healthcare should ensure that prisoners with severe hypokalemia are referred urgently to hospital.

3. The Governor should ensure that bereaved families have a clearly identified liaison officer at the prison who ensures that deceased prisoners' property is properly recorded and stored and returned to their families as soon as possible.

4. The Governor should ensure that the use of restraints for hospital and hospice escorts accurately reflects the prisoner's actual risk at the time, balancing both security and health, and is kept under frequent review.

ACTION PLAN: The man – HMP Wandsworth

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that all requests for follow up appointments are properly recorded and that administrative and security procedures do not delay or prevent prisoners attending important hospital appointments.	Accepted	The follow-up appointment process has recently been reviewed and improved. Details are now recorded electronically via SystmOne. Meeting to be arranged between HMP Wandsworth and Healthcare to discuss the challenges and solutions regarding healthcare appointments and security procedures.	Completed 01.09.13	
2	The Head of Healthcare should ensure that prisoners with severe hypokalemia are referred urgently to hospital.	Accepted	All GP's and Advanced Nurse Practitioners will receive a memo outlining the importance of referring patients with severe hypokalemia to hospital. Protocols are in the process of being developed for a telephone advice service between the hospital's Acute Medical Unit (AMU) and the Offender Healthcare Service (OHS). This will provide OHS GP's and nurses to be able to contact a consultant at the hospital's Acute Medical Unit (AMU) 24 hours a day for advice on complex cases. (The Offender Healthcare Service has commenced a 12 month work stream aimed at developing more integrated / joined up services between the OHS and the hospital – the advice line with AMU is the first step of what will be a complex and wide ranging service improvement	30.08.13 01.12.13	

			programme).		
3	The Governor should ensure that bereaved families have a clearly identified liaison officer at the prison who ensures that deceased prisoners' property is properly recorded and stored and returned to their families as soon as possible.	Accepted	Wandsworth has procedures in place for Family Liaison Officers (FLOs) and all FLOs will be reminded of the importance of recording, storing and returning property to families.	01.09.13	
4	The Governor should ensure that the use of restraints for hospital and hospice escorts accurately reflects the prisoner's actual risk at the time, balancing both security and health, and is kept under frequent review.	Accepted	The risk assessment procedure for hospital escorts will be reviewed by the head of security and head of safety. The revised procedure will ensure that hospital escort risk assessments take into account all relevant and up to date security intelligence and medical condition factors.	30.08.13	