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 September 2014 at 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 investigation report into the death of a man, who died of cancer in September 2014, at HMP Whatton. He was 48 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Whatton was undertaken. The prison cooperated fully with the investigation.

The man had been at HMP Whatton since October 2009. In December 2010, he reported having chest pain. A doctor considered he might have a leaky heart valve, but he refused investigative tests because he had a fear of hospitals. He agreed that prison healthcare staff should monitor his blood from then on. Tests were mostly normal, although he was sometimes slightly anaemic. He had no other health concerns.

In June 2014, the man told a doctor that he was passing black stools and had a bloated stomach. He agreed to tests, which showed he had terminal liver cancer, with a prognosis of a few months. Healthcare staff at the prison supported him well. They reviewed him regularly, amended his medications as necessary and fully involved him in his care planning. His condition deteriorated quickly and he died at the prison.

The clinical reviewer found that the healthcare the man received was equivalent to that he might have expected to receive in the community and I agree. However, I am concerned that officers restrained him for some hospital visits without fully considered risk assessments, which took into account how his poor health and mobility affected his ability to escape. This is a matter I have raised with Whatton a number of times before. I am also concerned that it took too long to submit and consider an application for compassionate release.

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 **April 2015**

CONTENTS

SUMMARY

1. On 7 October 2009, the man was sentenced to eight years in prison for sexual offences. He was sent to HMP Whatton on 29 October.

2. In December 2010, the man reported chest pain. The doctor thought he might have a leaky heart valve, but he refused any further investigation because he had a fear of hospitals. He agreed to have regular blood tests at the prison. Healthcare staff explained the risks of not having the tests and were satisfied that he had full mental capacity to make decisions about his health treatment.

3. For the next three years, healthcare staff monitored the man's blood. Tests were mostly normal but occasionally showed he was slightly anaemic. However, he refused to have further tests at hospital to investigate this. He occasionally complained of chest pain, but again refused to allow any investigation at hospital. Healthcare staff advised him of the risks, but he signed disclaimers.

4. In June 2014, the man told a GP that his stomach was bloated and he was passing black stools. A GP referred him for urgent investigative tests. He agreed to have the tests done, as long as he did not have to stay in hospital. The results of a CT scan on 24 June showed enlarged lymph nodes and a possible malignant tumour in his liver. On 11 July, after the additional tests, hospital staff told him he had terminal liver cancer and a life expectancy of a few months.

5. Each time the man went to hospital two officers escorted him and restrained him with handcuffs or an escort chain. The risk assessment remained the same even in August, by which time he was very unwell.

6. Healthcare staff supported the man well and reviewed him regularly. As his condition deteriorated, doctors amended his medication to control his pain. An application for release on compassionate licence made in August was rejected a month later. The prison asked for it to be reconsidered as his condition had deteriorated significantly in the meantime. He died at the prison before a further decision was made.

7. We are satisfied that healthcare staff at the prison tried to encourage the man to attend hospital for tests. Sadly, it was not until he was seriously ill that he agreed to other tests that revealed advanced liver cancer. No active treatment was possible. We agree with the clinical reviewer that he received a good standard of care at the prison, equivalent to that he might have expected to receive in the community. However, we are not satisfied that the use of restraints when he went to hospital was justified by fully considered risk assessments with healthcare input about how his condition impacted on his risk of escape. There were also delays with the handling of his application for compassionate release. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed one member of healthcare staff at Whatton on 18 November.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

11. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's mother, his nominated next of kin, to explain the investigation. His mother did not have any specific issues for the investigation to consider.

13. The man's family was offered the opportunity to receive the draft report once available. To date, we have received no further contact from the family.

14. The draft report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been added to the end of this report.

15. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

HMP WHATTON

16. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sexual offences.

17. Nottinghamshire Healthcare Foundation Trust provides health services at the prison. The healthcare centre is open during the week from 7.30am to 6.30pm. On Saturdays and Sundays, there is nurse cover from 8.30am until 1.30pm. A local out of hours service provides cover at night and at weekends. Specialist clinics are held for older prisoners and those with chronic conditions. There are no inpatient beds.

HM Inspectorate of Prisons

18. The most recent inspection of Whatton was in February 2012. The Inspectorate found the prison was safe and decent. Health services were generally good, with staff who were respectful and responsive to prisoners' needs. Primary care was well organised and prisoners had good access to nurse-led clinics, GP and dental services. There was a wide range of chronic disease clinics and enablement therapies to meet the needs of the population.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest published report for the year to May 2014, the IMB reported favourably on the standard of healthcare.

Previous deaths at Whatton

20. The man's death was the tenth from natural causes at Whatton since January 2013. (Whatton has a large percentage of older prisoners, which increases the number of deaths at Whatton in comparison to other prisons.) We have raised the issue of the inadequately justified use of restraints in a number of previous investigations.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

21. On 7 October 2009, the man was sentenced to eight years in prison for serious sexual offences. He initially went to HMP Nottingham and, on 29 October, transferred to HMP Whatton. He did not have any health concerns at the time.

22. On 17 December 2010, the man told a prison GP that he had chest pain. He refused an ECG, but had blood tests and a doctor prescribed aspirin and a glycerol trinitrate (GTN) spray. The blood tests showed a slightly low white blood cell count (which can be genetic and of no significance, or can be a sign of a viral infection) and slightly abnormal liver function.

23. On 18 January 2011, the man told a doctor that he no longer had chest pain. She noted he had a heart murmur and advised him to see a cardiologist, as it was possible he had a leaky heart valve. He refused, but agreed to have his bloods monitored.

24. Healthcare staff saw the man intermittently over the next three years. He had some infrequent chest pain, but still refused a referral to a cardiology clinic. His blood test results showed that he had slight anaemia, but he also refused investigative tests. He signed disclaimers to say he had refused hospital referrals and treatment, against medical advice. He said that he would not go to hospital, even if the cause of his symptoms could cause him harm or death. Healthcare staff were satisfied that he had the mental capacity to make these decisions.

25. On 27 May 2014, the man told a nurse that he had a bloated stomach. His clinical observations (such as blood pressure and temperature) were with the normal range. He did not have any other symptoms and his stomach was not tender. She advised him to contact healthcare staff if he had further concerns.

26. On 5 June, the man told a nurse that his stomach was bloated, he was constipated and he was passing black stools. She noted that his weight had been stable and his clinical observations were normal. She asked him to provide a stool sample and referred him to see a prison GP. He returned a stool sample the next day, which staff sent for analysis. Records show that the results stated the sample was lost or unusable. There is no record of a further sample test.

27. On 17 June, the man told a doctor that he had been bloated for a few weeks, he was eating normally and only had abdominal pain when he was lying down. The doctor noted his face looked thin, he had a very distended abdomen and fluid retention in his legs. She explained that his symptoms could be the sign of something serious and made an urgent referral to the

Nottingham Cancer Centre under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

28. On 19 June, the doctor told the man that he might have heart failure. He had a loud heart murmur, and the fluid retention had become worse. He said he would go to hospital for tests, but did not want to be admitted as an inpatient. She referred him to the hospital cardiology department.

29. On 24 June, the man went to hospital for a CT scan. He was also scheduled to have the fluid drained from his abdomen, but he refused to attend the appointment and signed a disclaimer.

30. The hospital faxed the results of the CT scan and a letter from the consultant to Whatton on 25 June. A nurse explained the results to the man that day. The scan showed he had widespread enlarged lymph nodes and an abnormal area in the right lobe of his liver, which suggested cancer. The scan also showed he had an enlarged heart. The consultant said the hospital should admit him for an echocardiogram, analysis of the water retained in his abdomen and a biopsy of his lymph nodes. The nurse advised him to speak to his parents before refusing to be admitted to hospital.

31. On 26 June, a doctor explained to the man that his heart disease might be treatable, but it would depend on how serious the possible cancer was. She said that if he did not have more tests, it would certainly shorten his life. He said he would speak to his parents, who lived abroad, and let staff know his decision in a few days.

32. After speaking to his parents, the man agreed to have the tests. On 2 July, an echocardiogram at hospital showed he had a significantly leaky heart valve, but he refused to be admitted to a ward. A hospital consultant explained that he had multiple swollen lymph nodes, which suggested he had cancer, but he said he did not feel unwell and had not lost any weight.

33. Doctors reviewed the man again in the cardiac outpatient clinic on 3 July. He again refused admission to hospital, but changed his mind the next day. On 4 July, the hospital admitted him for an infusion of furosemide (a diuretic that helps to reduce fluid retention), another echocardiogram and a CT scan.

34. On 11 July, hospital staff told the man he had liver cancer, which was terminal and his life expectancy was a few months. Surgeons decided not to operate on his heart valve, as his cancer was terminal. A multidisciplinary meeting, with prison healthcare staff present, agreed he should be nursed palliatively. Hospital staff kept him informed about his condition.

35. The man's initial reluctance to go to hospital made diagnosis difficult and, by the time he eventually agreed to tests, his condition was too advanced for active treatment. We are satisfied that healthcare staff at the prison did all they could to encourage him to attend tests and be assessed, and referred him appropriately. They explained the risks to him if he did not attend and

there were no doubts about his capacity to make decisions about his health care and treatment.

The man's clinical care

36. After his diagnosis, the hospital discharged the man back to Whatton on 15 July. The discharge letter from the consultant explained he was aware of his diagnosis and that he was not eligible for treatment. He said that the hospital had not given him enough information about his diagnosis and he wanted a second opinion. A nurse agreed to contact the liver specialist nurse at hospital for further information and to discuss the possibility of a second opinion. Nurses implemented a palliative care plan. On 16 July, the nurse tried to contact the liver specialist nurse, but was unsuccessful. She gave him a leaflet on liver cancer for additional information.

37. On 22 July, a doctor had a long discussion with the man about his condition and gave him a copy of the consultant's letter. He said he understood his life expectancy was two to four months, but still wanted a second opinion. He said he did not have any adverse symptoms and was eating and sleeping well. She noted that he had lost weight since she had last seen him. She offered him support and said she would review him in two weeks, but he could see her sooner if he wanted to.

38. The man became increasingly lethargic and, on 11 August, staff took him to the healthcare centre in a wheelchair. He told a nurse his appetite was poor and she arranged for him to have supplement drinks to help maintain his weight. A doctor reviewed him the next day. He said he did not have much pain and just needed paracetemol for intermittent use. He said he was aware of his prognosis, but only wanted to think one day at a time.

39. On 14 August, the man attended a consultant's appointment. The consultant made arrangements for a second opinion the next week, but when the time came, he refused to go the appointment. He said he knew nothing else could be done for him.

40. A prison GP reviewed the man on 26 August and changed his pain relief to cocodamol (a stronger paracetamol based medication) and prescribed something to help him sleep. They discussed whether he wanted to be resuscitated if he had a cardiac or respiratory arrest and he agreed to think about it.

41. On 9 September, a doctor noted that the man had deteriorated significantly and was only able to walk short distances. She increased his pain relief. A few days later, he began to use a three-wheeled walking frame to help him get about the wing.

42. On 15 September, the man told a doctor that he had no appetite, felt nauseous and was short of breath. He looked jaundiced and had significant fluid retention in his abdomen. The doctor prescribed anti-sickness medication and increased his diuretic to try to reduce the fluid retention. He

said he did not consider that attempting resuscitation would be dignified and signed an order to that effect. The doctor ordered anticipatory medication (to relieve pain and distress at the end of life) and discussed this with him.

43. During the night of 17/18 September, the man fell out of bed and officers helped him back. It was agreed that he should have an overnight carer from 18 September and that he should be nursed in bed from that point. In the early evening of 18 September, a doctor examined him, and found he was unable to move his right leg and was in pain. She decided he should have an X-ray to rule out a fracture and arranged for an ambulance to take him to hospital. Ambulance staff arrived after midnight, but did not take him to hospital as he said he was not in much pain.

44. On the morning of 19 September, a nurse gave the man morphine as cocodamol was not effective in managing his pain. He told a doctor later that day that he was not in any significant pain or discomfort and she noted that he seemed comfortable. An agency carer stayed with him during the night.

45. The man's breathing became laboured but he said he was comfortable and not in pain. He remained comfortable throughout the day and did not show any signs that he was in distress. A doctor considered he was nearing the end of his life. At 9.45pm, his carer noted that he had stopped breathing and did not respond to her. He had died peacefully in his sleep. A doctor attended the prison and certified his death.

46. The post-mortem report showed that the man died from carcinomatosis (multiple cancer sites) and liver cancer. He had also been suffering from bronchopneumonia and aortic valve disease. The fall from bed had not contributed to his death.

47. We agree with the clinical reviewer that the care the man received was equivalent to that he might have expected in the community. Healthcare staff reviewed his condition frequently and ensured that he received necessary pain relief. The healthcare staff gave good palliative care and involved him in his care planning.

The man's location

48. The man lived on a standard residential wing at Whatton and remained there throughout his illness. He said that he wanted to be near his friends on the wing and had told a nurse that he preferred to be cared for at Whatton rather than in hospital. The prison considered moving him to a prison with overnight healthcare, but he made it clear that he preferred to stay at Whatton and the prison did its best to accommodate his wishes.

49. As the man's condition deteriorated, staff moved him to a cell on the ground floor and then to a cell with a hospital bed. He remained content living on the wing and the prison ordered additional resources for him, such as an airflow mattress (to help reduce pressure sores), a special cushion and heel

protectors. We are satisfied that his location was appropriate at all times throughout his illness.

Restraints, security and escorts

50. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

51. The man attended hospital on 24 June for a CT scan. The escort risk assessment considered him a low risk to the public, staff and of escape or hostage taking, but he was fully mobile at the time. Two officers escorted him and restrained him with handcuffs. There was little healthcare input into the risk assessment, but it appears likely that if he was fully mobile at the time then the use of restraints might have been justified.

52. The man's condition deteriorated, with evidence of heart failure. He attended hospital on 2 July and was admitted on 3 July for treatment and additional tests. His risk assessments still indicated low risk in all areas, but the healthcare input was limited to indicating that there were no objections to the use of restraints. There was no information regarding his condition or how it impacted on his risk of escape. An escort chain was used for the journey to hospital, removed when he was in his room, but reapplied when he moved around the hospital.

53. On 14 August, the man attended an appointment with his consultant. By this time he had a diagnosis of terminal cancer; he was lethargic and very ill and the prison had assessed him as suitable for compassionate release. However, the risk assessment remained the same, with no additional healthcare input. Two officers escorted him and restrained him with an escort chain.

54. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. It is possible that the use of restraints for the earlier appointments was justified, but the healthcare contribution to the risk assessment was inadequate and did not comment on how his condition impacted on his risk of escape, as the 2007 High Court judgement requires. Despite his deteriorating condition, the risk assessment remained the same. Managers making decisions about the use of restraints

need to consider all the evidence, about a prisoner's health and mobility at the time. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

55. A prison family liaison officer was appointed. He introduced himself to the man on 26 July, explained his role and offered support. The man's parents lived abroad and he kept in contact with them by telephone.

56. On 20 September, when the man's condition deteriorated significantly, he said he did not want anyone to contact his family. However, based on previous conversations with him, a prison chaplain considered that he would want to see his grandmother and contacted her at 1.40pm. His grandmother and another family member visited him that afternoon, and he was pleased to see them.

57. After the man died, the family liaison officer rang his mother and grandmother to inform them. As his parents lived abroad, they had agreed that the prison should inform them of his death by telephone.

58. The family liaison officer assisted the man's family with the funeral arrangements and the prison contributed to the costs in line with national guidance. The prison held a memorial service on 30 September. The funeral was on 14 November, and the family liaison officer and another colleague from the prison attended.

59. We are satisfied that there was appropriate liaison with the man's family throughout his illness and after his death.

Compassionate release

60. 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 permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. 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. Application are dealt with by the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

61. After the man's terminal diagnosis, a manager at the prison started a compassionate release application. On 27 July, a doctor completed the healthcare section and said that the man would soon become very frail and would need extensive nursing care. His hospital consultant said that his condition was very advanced. On 7 August, his probation officer noted that release accommodation was being considered (pending additional information) and he endorsed the application, which the Governor supported. She sent the application to the PPCS on 18 August. The prison began to make further arrangements for his release should the application be successful.

62. On 16 September, PPCS rejected the application as the man was still mobile and not bedridden and his treatment was not incompatible with the prison environment. (Although his application was on the basis that he had a terminal illness and was likely to die soon, rather than because he was bedridden or otherwise incapacitated.) On 19 September, the PPCS was informed that his condition had deteriorated significantly in the month since the application had been submitted and he wanted to challenge the decision. He died before a further decision could be made.

63. In July, the man's consultant had told him that he had a prognosis of between two to four months so the need for urgency should have been apparent. However, it took almost a month to deal with the application in the prison and then a further month before the PPCS reached a decision, during which time the basis for the decision no longer applied. It does not appear that the prison kept the PPCS up to date about his condition in the meantime. While the outcome might still have been the same, we consider this should have been dealt with more quickly. We make the following recommendation:

The Governor and the Head of the Public Protection Casework Section should ensure that applications for early release on compassionate grounds are submitted and considered without delay and kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

2. The Governor and the Head of the Public Protection Casework Section should ensure that applications for early release on compassionate grounds are submitted and considered without delay and kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates.

Action Plan

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	Staff involved in the completion of risk assessments are advised of each prisoner's medical condition and mobility to ensure that any decision taken about the use of restraints is appropriate. Risk assessments for prisoners taken to hospital are based on consideration of the individual's circumstances and the actual risk the prisoner presents at the time. There is an underpinning regard to not only the individual's risk of escape but also their risk of harm to the public. Risk assessments for prisoners in hospital are dynamic and the use of restraints is reviewed, as necessary, to take into account any significant changes in circumstances. Specific ongoing consideration is given to medical opinion as to the use of restraints and the prisoner's condition and treatment, with reductions in the level of restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the	Head of Operations and Head of Healthcare Completed

			basis of continuous assessment of risk by the escorting staff in attendance. The Head of Operations completes a weekly check of discharges and in future this check will also quality assure the risk assessment in addition to the discharge process.	
2	The Governor and the Head of the Public Protection Casework Section should ensure that applications for early release on compassionate grounds are submitted and considered without delay and kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates	Accepted	All applications are processed by the Public Protection Casework Section once all the necessary information is received. The Head of Offender Management will introduce a better tracking system for compassionate release forms which will include a weekly review of active cases to ensure cases are checked and chased regularly.	Completed Head of Offender Management 31 March 2015