



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in October 2013,
while a prisoner at HMP Preston.**

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 oesophageal cancer on 23 October 2013, while in the custody of HMP Preston. He was 46 years old. I offer my condolences to the man's family and friends.

The man was remanded to HMP Preston in September 2012. At the end of October, he told a doctor that he had been suffering from a persistent cough. Over the coming months he reported a number of other concerning symptoms to healthcare staff, but insufficient was done to investigate the cause and identified follow up action was not pursued. The man transferred to HMP Wymott in May 2013. He listed a range of symptoms to the nurse in reception which should have prompted an urgent referral to a GP, but he did not see a GP until six weeks later. When he did, the GP immediately referred him to hospital specialists with suspected cancer. In July 2013, the man was diagnosed with cancer of the oesophagus which had spread to his lungs and liver. His condition was terminal and active treatment was not possible.

The clinical reviewer concludes that the standard of the man's healthcare in prison was poor and below the standard he could have expected in the community, principally because there was an unacceptable delay in diagnosis. While the general standard of care after his diagnosis was satisfactory, some aspects of his palliative care, such as pain relief could have been better managed.

I am also concerned that, on occasions, HMP Wymott required a very ill the man to be restrained for some stays in hospital without a fully considered risk assessment. However, I am pleased that, in the later stages of his illness, he was released on temporary licence so restraints were not used. Unfortunately, this humane approach was marred by a supervising officer unnecessarily encroaching on the private time the man's family were able to spend with him as he reached the end of his life.

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

June 2014

CONTENTS

Summary	5
The investigation process	7
HMP Preston	8
HMP Wymott	8
Issues	9
Recommendations	18
Action Plan	19

SUMMARY

1. The man was remanded to HMP Preston on 17 September 2012. He was sentenced to eight years and eight months imprisonment on 3 December. At the end of October, he reported to a prison GP that he had been suffering from a persistent cough for some weeks. His cough continued and he had some blood in his phlegm. In November, a GP referred him for an urgent chest X-ray. The hospital decided that this should be routine and the subsequent X-ray in December was clear. The referral is missing so we do not know what symptoms the GP reported.
2. Blood tests at the end of December were abnormal and could have indicated infection, cancer or inflammation. A GP initially attributed this to an infection, but requested that the blood tests should be repeated two weeks later. There is no indication that this happened. Over the next few months, the man saw a number of nurses at Preston and reported a range of concerning symptoms, including changes to his urine and blood in his phlegm. The nurses requested urine and sputum samples, but these do not appear to have been obtained and no follow up action was taken.
3. On 9 May 2013, the man transferred to Wymott. He reported a number of symptoms to the nurse who conducted his reception health screen which should have led to an urgent referral to a GP, but she made only a routine referral. A GP did not see the man until six weeks later, when he referred him urgently to hospital specialists because of suspected cancer. On 2 July, the man was diagnosed with cancer of the oesophagus which had spread to his lungs. Later in July, it was noted that the cancer had also reached his liver. His condition was incurable and only palliative treatment was possible. Doctors estimated that he had between six and twelve months to live.
4. The man moved back to HMP Preston on 22 August to be cared for in their inpatient unit. Appropriate care plans were put in place and his care was generally satisfactory, but the clinical reviewer noted that management of the man's pressure sores did not follow NHS best practice and pain relief could have been more effective.
5. At the end of September, he moved to a hospice. His condition stabilised and he was discharged back to the prison after ten days. On 17 October, the man was admitted to the Royal Preston Hospital for a blood transfusion. He was released on temporary licence with an officer accompanying him for support. His family were with him when he died at the hospital on 23 October.
6. The clinical reviewer does not consider that the man's medical care was equivalent to the standard he could have expected in the community. His symptoms were not acted on sufficiently urgently and this led to an unacceptable delay in diagnosis. We are also concerned that restraints were used for hospital appointments with little evidence that his serious physical condition and limited mobility was taken into account or that the risk was reviewed when circumstances changes. The man's family were concerned that one of the prison officers who accompanied him in hospital the day before

his death was not sufficiently sensitive to the situation. We consider that as the man had been released on temporary licence the officer should have allowed his family more private time with the man. We make five recommendations about these issues.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.
8. The investigator obtained copies of the man's prison and prison medical records. She interviewed six members of staff at HMP Wymott on 16 January and conducted two further telephone interviews on 20 and 27 January. The investigator gave the governors of Preston and Wymott initial feedback in writing.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. The investigator informed HM Coroner for Preston and West Lancashire District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation process. The man's sister was concerned about the timeliness of his diagnosis and his location. She believed he had not been given sufficient counselling and support after his diagnosis. She identified some problems with aspects of his clinical care and was unhappy about the conduct of a prison officer at hospital. The man's sister wanted to know why her brother had not been released on compassionate grounds.
12. The man's family received a copy of the draft report. They pointed out some factual inaccuracies and omissions. This report has been amended accordingly. The man's family also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
13. The prison considered our draft report and its recommendations and has accepted these. No factual inaccuracies were raised. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.
14. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, liaison with his family, his location, security arrangements and whether compassionate release was considered.

HMP PRESTON

15. HMP Preston is a local prison holding up to 842 adult men. Health services are provided by Lancashire Care Foundation Trust. There is an inpatient unit for up to 30 prisoners which is used as a regional facility. Inpatients remain the responsibility of their original prison for all aspects except healthcare.

HM Inspectorate of Prisons

16. The last inspection of HMP Preston was in April 2012. Inspectors found that an appropriate range of health services were provided. Primary care services had improved and inpatient services were satisfactory.

Independent Monitoring Board

17. 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 most recent annual report for 2013, the IMB concluded that the healthcare department at Preston appeared very effective.

Previous deaths at HMP Preston

18. The man was the seventh prisoner to die of natural causes at HMP Preston since the beginning of 2011. In a previous investigation report, we made a recommendation that nurses should be trained in palliative care.

HMP WYMOTT

19. HMP Wymott is a category C prison holding over 1,100 adult men. Healthcare services are commissioned and provided by NHS Central Lancashire. A private company provides GP services. There are no inpatient beds, but there is nursing cover 24 hours a day.

HM Inspectorate of Prisons

20. The last inspection of HMP Wymott was in November 2011. The report said that healthcare staff were well integrated into the prison. Inspectors were critical of the long wait that some prisoners experienced to see a GP.

Independent Monitoring Board

21. In their 2012/13 annual report, Wymott IMB was concerned about the inconsistent provision of GP services. Although urgent cases were seen promptly there appeared to have been an increase in waiting times for non-urgent appointments.

Previous recommendations

22. We have made a number of previous recommendations to HMP Wymott about risk assessments for the use of restraints.

ISSUES

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

23. The man was remanded to HMP Preston on September 2012 and sentenced to eight years and eight months in December. At his reception health screen the man disclosed a history of heavy drinking and liver problems. He said that he had suffered from depression.
24. On 25 October, the man told a GP at the prison, that he had suffered from a persistent cough for five weeks. The GP noted that the man's lungs were clear and he should be reviewed in a week or two if his symptoms persisted.
25. On 16 November, another doctor examined the man and noted that he said he still had a cough, with green phlegm streaked with blood. He prescribed antibiotics and made an urgent referral for a chest X-ray but did not take a sputum sample. There is no copy of the X-ray referral form in the man's medical record and no follow-up plan was recorded.
26. An undated letter from the Royal Preston Hospital said that they would see the man for a routine X-ray, which was carried out on 11 December. The results were clear. A report from the consultant radiologist identified no active chest disease and the man's heart was not enlarged.
27. The man had blood tests taken on 28 December. The results identified a raised ESR (erythrocyte sedimentation rate) and white cell count. The clinical reviewer notes that raised ESR is a marker for infection, inflammation and cancer. The doctor attributed the results to a chest infection but asked for the blood tests to be repeated in three to four weeks. There is no record that this happened.
28. On 19 January 2013, the man told a nurse that he was passing 'whitish' urine. She gave him a specimen jar, but there is no record that the man provided a urine sample or that this was followed up. On 25 January, the man complained to the nurse that he was coughing up blood and had a burning sensation when producing phlegm. She could not see any traces of blood when he coughed so she gave him a specimen jar for sputum and asked him to give it to a member of healthcare staff to be investigated further. There is no record that the man provided a sputum sample, or that this was followed up.
29. On 11 March, the man reported to a doctor that he had lost weight. There is no record that he was weighed or referred for further investigation.
30. On 4 April, the man told nurse that he still had a productive cough and she advised him to return with a sputum sample. There is no indication that his previous history and complaints of similar symptoms were considered and the nurse did not refer the man to see a doctor.

31. On 1 May, the nurse saw the man at a routine health monitoring clinic. She noted that his general observations were within normal limits. The man told her that he was concerned that his urine was a darker than usual and that he had been feeling very sick and had lost a lot of weight. There is no record that the nurse checked the man's weight and she recorded that he should be reviewed in six months.
32. On 9 May, the man transferred to HMP Wymott. When he arrived he told the nurse that he had not seen a GP for some months, but had reported weight loss and stomach pains to a nurse. The man told the nurse that he had a burning sensation when he ate and drank and that he often vomited. The nurse did not refer the man to a GP urgently to investigate these symptoms, but made a routine referral instead. The Head of Healthcare told the investigator that she would have expected an urgent referral to have been made, but in any event it was likely the man would have seen a GP as a 'matter of course'. The man did not see a GP until six weeks later.
33. The nurse saw the man on 10 June for a routine check for suspected hepatitis C. There is no record to indicate she discussed his current symptoms with him.
34. On 20 June, when the man was collecting his medication, he told another nurse that he had lost a lot of weight in the previous two months and that he had been vomiting for a week. The nurse noted that the man had an appointment booked with the GP on 24 June so took no further action.
35. A doctor examined the man on 24 June. The man told him that he had been vomiting and that his vomit contained dark red blood. He said that he had lost four kilograms in three months. The man described himself as a heavy smoker and said that in the past he had been exposed to asbestos when he worked for a demolition company. The doctor made an urgent referral to a specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
36. On 2 July, the man attended the Royal Preston Hospital chest clinic. He had an X-ray, a CT scan and blood tests. Hospital staff informed the man that the results confirmed a diagnosis of oesophageal cancer, which had spread into his lungs. Later scans found cancer had also spread to his liver. Doctors told him the cancer was incurable and, on 23 July, estimated he had between six and twelve months to live.
37. The clinical reviewer considers that the length of time between the man presenting with symptoms and his diagnosis was unacceptable. He notes that most of the delay was at HMP Preston, where abnormal blood tests were not followed up and the serious symptoms which the man reported were not sufficiently investigated. Three different prison GPs missed the opportunity to evaluate the situation fully. The clinical reviewer considers that explaining a raised white blood count and ESR as a chest infection and the failure to have any robust follow up plans, including when nurses requested sputum samples, amounted to "a serious failing in clinical acumen and systems." When the

man arrived at HMP Wymott the failure to act on his reported symptoms led to another unacceptable delay. The clinical reviewer considers that healthcare staff at both prisons need to have a more proactive approach to diagnosis, a much lower threshold of suspicion and greater vigilance. We make the following recommendation:

The Head of Healthcare at Preston and Wymott should ensure that nurses refer prisoners to see a GP when they report concerning symptoms, that GPs refer to specialists appropriately and that actions identified at consultations are followed up.

38. After his diagnosis on 2 July 2013, the Head of Healthcare at Wymott, spoke to him about how he was feeling and referred him to the mental health team. The man had harmed himself in the past so staff began ACCT procedures (Assessment, Care in Custody and Teamwork – the Prison Service process for supporting someone at risk of self-harm or suicide). The next day, a member of staff from the mental health team attended an ACCT review meeting with the man. All agreed that the man was coping well after his diagnosis and the ACCT plan was closed. There are no records that the man received any further mental health input but he was subsequently well-supported by healthcare staff, including palliative care nurses, at Wymott.

The man's medical treatment

39. After his diagnosis, a doctor saw the man and prescribed co-codamol to help manage his pain. On 17 July, he was prescribed tramadol (for moderate to severe pain). On 21 July, the man told another doctor that he was persistently in pain and the doctor prescribed dihydrocodeine (another medication for moderate to severe pain).
40. No active treatment was possible to cure the man's cancer. On 22 July, the man was admitted to the Chorley and South Ribble Hospital to have a stent fitted to help him swallow. He returned to Wymott on 27 July.
41. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place. 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 plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.
42. The head of healthcare contacted the prison palliative care lead on 26 July and referred the man for assessment. On 29 July, the palliative care lead and another nurse (from HMP Preston) met the man and discussed his diagnosis, prognosis and on going support and care. Although at this stage the man was relatively independent, the provision of future social care was also discussed.

On 1 August, the palliative care lead discussed the man's case with a palliative care nurse, from St Catherine's Hospice, Preston.

43. Throughout July, the man's pain relief medication was frequently reviewed and, by August, he was prescribed oramorph (oral morphine solution) and morphine sulphate (strong opioid pain relief).
44. Records show that the man received some smoking cessation advice and nicotine patches on 31 July.
45. On 6 August, the palliative care nurse contacted the nurse from the hospice again for advice about managing the man's nausea and other symptoms. Staff from the hospice visited on 10 August and assisted with care plans and pain management. The man's pain relief was increased, but the next day the man said he was still in pain.
46. On 13 August, the man had an appointment at the Royal Preston Hospital. It is not clear from the records what this was for. On 21 August, the man spent a night at the Royal Preston Hospital. When he was discharged the next day, he was prescribed diamorphine injections (another strong pain relief medication).
47. On 22 August, due to his increased care needs, the man moved to the inpatient unit at HMP Preston. The next day, a nurse started an end of life care plan and noted that St Catherine's Hospice staff had reviewed the man a number of times. Records show that the man's pain relief was variable over the next few weeks.
48. On 3 September, the palliative care nurse advised anticipatory prescribing of end of life medication including midazolam (a sedative) and levomepromazine (to ease pain, restlessness, anxiety and vomiting) in case it should be needed at short notice. It is not clear whether this was done.
49. On 6 September, healthcare staff from Preston and Wymott, the man and three members of his family met to discuss his ongoing care. His family was concerned that he would have to get out of bed to use a cell bell to summon help if he needed it and it was agreed that a two way monitoring system would be set up. The man was unhappy that he was unable to smoke in the inpatient unit and after the meeting, the nurse asked the head of residence if arrangements could be made for the man to smoke elsewhere. The head of residence said this would be impractical.
50. That day, 6 September, the man was admitted to the Royal Preston Hospital for a blood transfusion and an abdominal ultrasound. He stayed in hospital for 11 days before returning to the prison.
51. On 27 September, the man moved to St Catherine's and stayed there for ten days. His condition stabilised and the hospice discharged him back to Preston. The hospice had fitted a syringe driver (a small pump used to give a continuous dose of painkilling medication). Healthcare staff at the prison

noted that he had developed a mild pressure sore. By mid-October, the sore had deteriorated significantly. A nurse told the investigator the man was on a two hourly turn regime, but sometimes refused to move and even an occasional refusal can be detrimental when the skin is breaking down.

52. On 7 October, the man requested further nicotine replacement patches, however the records do not show whether he received these. On 8 October, the man agreed with the nurse that he did not want to be resuscitated in the event of cardiac or respiratory arrest. He signed a formal order with this instruction, which was reviewed with him regularly. That day, the records indicate that the man's prescription chart was not available. The reason is not recorded but, because of this his medication through the syringe driver was stopped. At 4.14am the next morning, a doctor instructed that the man should be given oramorph and oxynorm liquid pain relief.
53. A multi-disciplinary meeting was held on 10 October to provide support for the man, his family and staff working with him. The head of healthcare said she had gone to see the man before the meeting but he had not wanted to attend. The man's family maintain that this did not happen until they insisted he be invited.
54. We are satisfied that the man had appropriate care plans at Preston and his family were fully informed and involved in discussions about his care and treatment. The clinical reviewer noted some omissions about social needs such as his wish to be able to smoke but recognised that the constraints of the prison environment made this difficult.
55. The clinical reviewer noted that treatment of the man's pressure sores did not adhere to NHS best practice. He also concludes the man's pain management was not effective as it could have been.

The Head of Healthcare at Preston should ensure that healthcare staff follow NHS best practice for preventing and treating pressure sores.

The Heads of Healthcare at Wymott and Preston should ensure that clinicians are trained in palliative care with particular emphasis on pain and nausea management.

The man's location

56. After his diagnosis, the man wanted to remain at Wymott. He was concerned about the standard of care he would receive at Preston as he felt staff there had not reacted appropriately to his early symptoms. He moved to a ground floor cell on his wing and efforts were made to care for him at Wymott as long as possible. As his health got worse he needed 24 hour inpatient care and moved to Preston's healthcare unit on 22 August.
57. On 27 September, the man was released on temporary licence to St Catherine's Hospice. The hospice discharged him 10 days later when his condition had stabilised and the hospice was confident that his needs could

be met sufficiently well as an inpatient in HMP Preston's healthcare unit. On 17 October, the man went to the Royal Preston Hospital for a blood transfusion and remained there until he died on 23 October.

58. We are satisfied that staff at Wymott respected the man's wish to remain there as long as possible. We agree with the clinical reviewer that he was moved to Preston appropriately, as the healthcare unit there was better equipped to provide an appropriate standard of end of life care when it became necessary.

Restraints, security and escorts

59. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. 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. It also 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.
60. The judgement made it clear that fresh risk assessments must be conducted each time a seriously or terminally ill prisoner is moved or their clinical condition is reviewed and that the conditions of restraint applied during a prisoner's stay at hospital should be assessed separately from the conditions of restraint used on escort. Assessments needed to be made at the start of each period of stay at hospital and reviewed regularly or when circumstances changed.
61. The man was diagnosed with cancer on 2 July 2013. On 23 July 2013, he had an appointment at the Royal Preston Hospital for further examination and discussion with doctors about his diagnosis and life expectancy. The medical section of the security risk assessment was completed and did not object to the use of restraints and considered that the man had the ability to escape. The assessment noted that handcuffs would not need to be removed for the appointment, but could be replaced by an escort chain if necessary. The man was assessed as a low risk to children, of hostage taking or escape, a medium risk to hospital and prison staff and a high risk to the public. A prison manager authorised the use of single handcuffs and two escorts. Restraints were to be removed in the event of a medical emergency or if they impeded treatment or examination.

62. On 24 July, the man was taken to hospital for an X-ray. Subsequently he was admitted to have a stent fitted. He remained in hospital until 27 July. The risk assessments were the same as the previous day. There is no evidence that the risk assessment was reviewed when it was decided he needed to stay in hospital or during his stay. The records do not show that restraints were removed during the procedure to fit the stent.
63. On 13 August, the man attended the Royal Preston Hospital. The medical assessment, completed by a nurse differed from those completed previously. This time she noted that the man needed a wheelchair for each part of the transfer and was in a lot of pain and vomiting. The security assessment remained the same and the manager again decided that single handcuffs should be used and that the man should be escorted by two officers. On 21 August, the man was admitted to hospital again overnight. He was restrained on the journey as before, but restraints were removed once he was at the hospital and the officers waited in a room opposite.
64. The man was released on temporary licence when he was admitted to St Catherine's hospice on 27 September and again on 17 October when he was admitted to the Royal Preston hospital so no restraints were used.
65. However, we note that restraints were used on some earlier occasions without a fully justified risk assessment which fully considered all the circumstances and how his health and mobility affected his risk. On 24 July, the risk assessment was not reviewed before the man underwent treatment and stayed in hospital. On 13 and 21 August, the man's was in poor physical health and had limited mobility, which required him to use a wheelchair. This meant his risk of escape and (therefore the possibility of him being a risk to the public should be escape) was very low. Despite this, he was restrained on each occasion and it does not appear that the additional information contained in the medical section was taken into account. We make the following recommendation:

The Governor of Wymott should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including how their health and mobility impacts on their risk of escape, and that assessments are reviewed in hospital as circumstances change.

Liaison with the man's family

66. When the man was in hospital on 8 September, the prison family liaison officer from Wymott introduced himself to the man's family. He explained that he would be their main point of contact. After his diagnosis staff from Wymott and Preston kept in contact with the man's family and involved them in meetings about his care.
67. The man's family were able to visit him in prison and hospital and he was given special permission to use a mobile phone for five minutes a day to contact them. The man's family have told us that the man only used the

mobile phone once, but the investigation found no evidence to suggest that the prison hindered his access to it.

68. When the man went to hospital on 17 October, in the days before he died, he was released on temporary licence. As part of his licence conditions for temporary release, the man was not allowed to access a computer or the internet or contact a named person. An officer accompanied him for support. The man's family told us that most officers who accompanied him sat outside the room rather than next to his bed. This allowed his family private time with him in the days leading up to his death.
69. On 22 October, the day before he died, when the man was very ill, the accompanying officer refused to leave his bedside because he believed he had to ensure that he supervised the man closely to make sure he did not access the internet. This caused one of his sisters, who was sitting with him, some distress. She said she had asked the officer to sit outside the room, as other officers had done, but he refused.
70. The man's sister was staying in the hospital that night because he was very ill. She said that when she left his bedside for the night, she passed her mobile phone number to the officer and asked to be called if the man's condition deteriorated. The officer did not pass this on to the next officer on duty. The next officer on duty said that the officer was sitting close by the man's bed when he arrived. The officer sat by the nurses' station from where he could see the man. When the man's condition deteriorated in the night, the officer called another sister, his nominated next of kin, as he was unaware that his other sister was at the hospital. She then contacted her sister at the hospital.
71. We are satisfied that overall there was appropriate liaison with the man's family. After the man's death, in line with national policy, HMP Wymott contributed towards the cost of his funeral, which was held on 4 November 2013. Unfortunately, the general good standard of family contact was marred by the apparent over zealous supervision by an officer in hospital. This should not have been necessary for a prisoner judged as suitable for release on temporary licence in the days before his death. We make the following recommendation:

The Governor of Wymott should ensure that officers accompanying seriously ill prisoners who are released on temporary licence are fully briefed and understand their supportive role and that family members have appropriate private time with them before their death.

Compassionate release

72. 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. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. 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).

73. On 29 July, when the man was at Wymott, the palliative care lead discussed the possibility of compassionate release. An application for compassionate release was started, but this was not supported by the prison Governor as the man did not fully meet the criteria. The Probation Service did not support release as there was no robust release plan. The man was not being considered for a hospice place at that time. On 15 August, the Governor formally refused the application.
74. However, at the end of September, the man's condition deteriorated and his transfer to a hospice was urgently considered. The Governor reviewed the application and submitted it to the public protection casework section on 27 September. They asked for clarification about whether the man was going to remain at St Catherine's Hospice but by this time he had been discharged from the hospice and had returned to Preston for care. The Probation Service reviewed alternative proposals for release accommodation, but nothing suitable was found. As a result the prison did not resubmit the application.
75. The application for compassionate release was reviewed again when the man's health deteriorated on 17 October and he was admitted to Royal Preston Hospital. A release plan to a hospice was being considered, but the man died before a suitable placement could be found and the application progressed.
76. We are satisfied that prison staff appropriately considered compassionate release when the man was diagnosed, and reviewed the application when his health deteriorated.

RECOMMENDATIONS

1. The Head of Healthcare at Preston and Wymott should ensure that nurses refer prisoners to see a GP when they report concerning symptoms, that GPs refer to specialists appropriately and that actions identified at consultations are followed up.
2. The Head of Healthcare at Preston should ensure that healthcare staff follow NHS best practice for preventing and treating pressure sores.
3. The Heads of Healthcare at Wymott and Preston should ensure that clinicians are trained in palliative care with particular emphasis on pain and nausea management.
4. The Governor of Wymott should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including how their health and mobility impacts on their risk of escape, and that assessments are reviewed in hospital as circumstances change.
5. The Governor of Wymott should ensure that officers accompanying seriously ill prisoners who are released on temporary licence are fully briefed and understand their supportive role and that family members have appropriate private time with them before their death.

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare at Preston and Wymott should ensure that nurses refer prisoners to see a GP when they report concerning symptoms, that GPs refer to specialists appropriately and that actions identified at consultations are followed up	Accepted	<p>A review of the patient pathway and triage process will be undertaken to ensure appropriate and timely intervention when patients present 'red flag' symptoms. During the review period, staff will access the <i>Management of the Same Day Consultation</i> module at the University of Central Lancashire.</p> <p>Cancer awareness training, delivered by the cancer care network, is also scheduled to take place in May to assist clinicians with the early identification of cancer and appropriate referrals.</p> <p>All healthcare professionals have been reminded of their responsibilities regarding emergency referrals and urgent same day referrals to the GP.</p> <p>This recommendation has been discussed at the GP forum, where GPs were reminded of the need to refer patients for urgent appointments when they present 'red flag' symptoms.</p>	<p>Healthcare Managers at HMP Preston and HMP Wymott</p> <p>August 2014</p>	
2	The Head of Healthcare at Preston should ensure that healthcare staff follow NHS best practice for preventing and treating pressure sores.	Accepted	Healthcare staff have been reminded of the importance of following best practice guidelines regarding pressure sore care and management. All patients located on the inpatient facility now have regular pressure sore risk assessments undertaken and a care plan in place where appropriate.	<p>Healthcare Manager</p> <p>Complete</p>	

3	The Heads of Healthcare at Wymott and Preston should ensure that clinicians are trained in palliative care with particular emphasis on pain and nausea management.	Accepted	<p>All GP's that work within Lancashire prisons have access to the lessons learnt from deaths in custody and Serious untoward incidents (SUI's), which are discussed at the GP forum.</p> <p>The Lancashire prison palliative care pathway is currently under review with the palliative care consultant. The principle GP will ensure that the ratified policy is shared with GP forum members.</p> <p>All prescribers and healthcare providers within both prisons are able to access the current prescribing formulary, which encompasses the anticipatory medication for end of life care.</p>	<p>Healthcare Managers at HMP Preston and HMP Wymott</p> <p>August 2014</p>	
4	The Governor of Wymott should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including how their health and mobility impacts on their risk of escape, and that assessments are reviewed in hospital as circumstances change.	Accepted	<p>Managers who discharge escorts, and those conducting bed watch checks, have been reminded of their responsibility to ensure that risk assessments reflect the actual level of risk presented.</p> <p>Risk assessments now being completed take into account a prisoner's individual circumstances, level of health and mobility and how these impact on their risk of escape. Assessments include input from Healthcare staff and are reviewed when there is any change of circumstances.</p>	<p>Governor</p> <p>Complete and ongoing</p>	
5	The Governor of Wymott should ensure that officers accompanying seriously ill prisoners who are released on temporary licence are fully briefed and understand their supportive role and that family members have appropriate private time with them before their death.	Accepted	<p>This has been discussed with managers and a notice has been issued to staff reminding them of their responsibilities.</p>	<p>Governor</p> <p>Complete and ongoing</p>	

