PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man in December 2010 at a hospice while in the custody of HMP Brixton

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

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This is the report of an investigation into the circumstances surrounding the death of a man at a hospice whilst he was a prisoner at HMP Brixton. He died in December 2010 from liver cancer aged 41.

I would like to pass my condolences to the man's family. I would also like to apologise for the delay in issuing this report and any further distress that this may have caused.

The investigation was carried out on my behalf by one of my Investigators. A clinical review of the man's healthcare was undertaken by a clinical reviewer on behalf of NHS Lambeth. I am grateful for her report. I would also like to thank the Governor of Brixton and his staff for their co-operation, although I am drawing to the attention of NHS Lambeth the refusal of one of their staff to be interviewed by my Investigator, a matter which should be viewed seriously.

The person who is the subject of this report was a young man who had been dependent on drugs for several years. However, during his time at Brixton he successfully underwent a detoxification programme.

Unfortunately, this investigation exposed a lack of co-ordination in the approach to the man's care by healthcare staff, including a delay of over a year in referring him to a hepatologist for his positive diagnosis of hepatitis C. In the view of the clinical reviewer, this might have significantly altered the man's care plan at Brixton. As a result, this report recommends improvement of referrals to medical specialists, it also calls for better prioritisation where hospital appointments are cancelled due to a shortage of prison escort staff and for appropriate debriefs for healthcare staff following a death in custody. A recommendation is also made to ensure that formal assessments for compassionate release are made in all appropriate cases. Finally, I have made a national recommendation to the Department of Health to ensure that all healthcare staff working in prisons are aware of the requirement to cooperate with a death in custody investigation.

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 **July 2012**

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SUMMARY

1. The man was initially taken to HMP Brixton on 5 September 2009 from a magistrates' court, where he was remanded into custody. On 23 April 2010, he was sentenced to seven years in custody.

2. The man was a long term drug and alcohol user when he arrived in prison. He successfully undertook a detoxification programme whilst at Brixton. In 2008 he tested positive for hepatitis C. Despite this being brought to the attention of healthcare staff when he first arrived at Brixton, he was not referred for specialist treatment until September 2010.

3. At the start of September 2010, the man's cell mate approached healthcare staff to express concern about his fellow cell mate's health. He said that his cell mate had been vomiting and coughing up blood. On 8 September, the man collapsed in his cell and he was taken to outside hospital. Whilst in hospital he received a diagnosis of liver cancer.

4. Hospital specialists decided that the man's condition was only suitable for palliative care. He was moved to a hospice in November 2010, where he died on a day in December.

5. Towards the end of his life, the man's family were able to visit him from Scotland, including his mother and brother. His brother was with him when he died. His family expressed concern that consideration was not given to moving him to a hospice closer to their home in Glasgow. Repatriation was considered once by senior staff at Brixton. However, they concluded that this would prove extremely difficult because custodial warrants issued in England and Wales were not valid in Scotland. He was formally assessed for release on temporary licence once and was not considered for release on compassionate grounds.

6. There are a number of areas where the man's care could have been improved. We make three recommendations relating to healthcare including the need to improve care of those with chronic conditions, escort arrangements for outside hospital appointments and need to hold debriefs after a prisoner's death. A further recommendation is made about assessing terminally ill prisoners for temporary release on compassionate grounds.

THE INVESTIGATION PROCESS

7. The investigation was undertaken by one of my Investigators. She first visited Brixton on 8 December 2010 and was given access to the man's prison records. She saw the healthcare unit and the unit where the man lived during his time at the prison.

8. During this initial visit, the Investigator met members of the Independent Monitoring Board (IMB), the prison chaplain and the Prison Officers Association (POA). She invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they thought relevant to the investigation. (Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.) Neither the IMB, the POA nor the prison chaplain had any specific matters to bring to the Investigator's attention at the time. The Investigator also ensured that notices to staff and prisoners were displayed at the establishment, particularly in areas where the man had lived and worked.

9. During the course of the investigation the Investigator interviewed two prisoners who were on the same wing as the man at Brixton. One of the prisoners shared a cell with him. The Investigator also interviewed the Deputy Governor at Brixton.

10. Lambeth Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the man received whilst he was in custody at Brixton. The Investigator asked the clinical reviewer to consider particularly whether the prison health authorities had acted promptly in identifying the man's condition and whether there had been any delay in his treatment. The clinical review was undertaken by a clinical reviewer on behalf of the PCT. She interviewed two members of the healthcare team at Brixton and attempted to interview a third. This member was asked to attend an interview on two occassions and declined to attend both times. This is referred to in more detail later in the report.

11. One of the Ombudsman's family liaison officers contacted the man's mother and brothers, as his family, to explain the purpose of my investigation and to invite them to ask any questions or raise any issues for consideration. The Investigator and the family liaison officer visited the family at home and they asked some questions which I have detailed below:

    - Why was their relative's family not informed by Brixton that he was in prison?
    - Why was their relative not moved to a hospice closer to his family's home in Glasgow?
    - Were appropriate restraints used during their relative's time in the hospital and hospice, given that he was so unwell?

12. It is to be hoped that the report clarifies any issues that might remain unclear for the man's family and helps them to better understand what happened in the time leading to his death.

13. The Investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of the report will be sent to the Coroner.

14. The issuing of this report has been delayed due to workload pressures within the Ombudsman's office. The clinical review was received from the Primary Care Trust on 18 May 2011.

15. The man's family received a copy of the Ombudsman's draft report. No further representations were made in response to the findings. The National Offender Management Service (NOMS) response to the recommendations is included in page 19.

HMP BRIXTON

16. Brixton is a closed local prison for sentenced and remanded adult men. It is a very busy prison serving a number of courts in South London, with many prisoners attending court each day.

17. The prison's population rarely falls below its operating capacity of 798. The average length of stay for a prisoner is around eight weeks, although this man had been located at Brixton since his arrest in September 2009.

18. There are four main residential units. A wing, where this man was located, is the largest wing with an operating capacity of 264. The wing is used to house the prison's workforce and those attending education classes.

19. A new contract for healthcare services was started in 2008 which meant that healthcare was provided by a consortium led by Care UK, with Lambeth Primary Care Trust as the commissioner of services.

20. In their 2009/2010 report, the prison's Independent Monitoring Board says that there have been positive changes within healthcare at Brixton, and that a good relationship has been forged between the Head of Healthcare and the IMB. In this report they say:

> 'More generally, there are recurrent problems about prisoners' access to routine healthcare because of the restrictions in the regime, although the dispensaries on the wings are helpful. Care UK and the prison management have been co-operating to reduce the number of missed appointments, and there is a patient forum.'

21. In her report of an announced inspection in May 2008, HM Chief Inspector of Prisons, acknowledged the difficulties Brixton faced in respect of limited resources and a challenging population with diverse needs.

ISSUES

The man's medical appointments and treatment

22. When the man arrived at Brixton on 5 September 2009 he underwent a reception health assessment. This identified that he was dependent on heroin and cannabis. The clinical reviewer has commented that there was no evidence that the man's General Practitioner (GP) was contacted in regard to his past medical notes. During the reception screen, he denied seeing his GP within the last six months or having any long term conditions or outstanding GP or hospital appointments. Although the man's GP should have been contacted for his medical records, the clinical reviewer considers that, under the circumstances, it was not unreasonable that this was not done.

23. During his time at Brixton the man was regularly seen by the substance misuse team. His methadone dosage was gradually reduced and he successfully completed a detoxification programme on 7 July 2010. The clinical reviewer considers that the man's substance misuse issues were managed appropriately.

24. The clinical reviewer has commented that the man received excellent dental care during his time at Brixton. He was seen no less than fourteen times for a course of treatments, which included treatment for infection, tooth extraction and the fitting of dentures. The on-going care regarding the removal of his teeth and fitting of his dentures finished one month before he was admitted to outside hospital.

25. In 2008, the man had been diagnosed as hepatitis C positive. During his first reception health screen on 5 September 2009, he declined to be re-tested for this condition or to receive any immunisation. He was reviewed by a prison doctor on 11 September 2009. There is no record that his hepatitis C was discussed. On 10 November, he was reviewed by another prison doctor. The man asked for further investigation into his hepatitis C and said he would like to be considered for treatment for this condition. However, there is no evidence on his medical file that a referral was made. The clinical reviewer has commented that the man's diagnosis of hepatitis C appears to have been overlooked until approximately a year later in September 2010 when the first prison doctor the man had gone to see wrote to a consultant hepatologist (a specialist in diagnosing and treating liver disease) at outside hospital. The same doctor also prescribed the man antibiotics.

26. It has not been possible to establish why the man's hepatitis C diagnosis was not acknowledged and a referral for more specialist care not made until September 2010, when he was finally referred to the hepatology department at outside hospital. However, it is worthy of note that during the course of the investigation, the first prison doctor declined to be interviewed on two occasions, which made this situation particularly difficult to clarify. The clinical reviewer has commented that the man may have refused any clinical input regarding his hepatitis. It is noted that he refused to be re-tested whilst he was in prison and, in reception, also initially denied having any long-term

conditions. However, the clinical reviewer concludes that, if the man had been seen before he became more acutely unwell, his care pathway may well have been very different. We share her view and make the following recommendation:

Prisoners who have a diagnosis of any long term or chronic condition should have an appropriate care plan, including referrals for specialist care as appropriate.

27. On 2 September 2010, the man's cell mate approached a member of healthcare staff to express concern about his condition. His cell mate said he had witnessed episodes of his vomiting blood which he described as fresh. He also said his cell mate had been experiencing abdominal pains for a few days. The nurse noted that the man was due to see the GP on the following day and if he didn't attend this should be followed up. On 8 September, the man's cell mate asked healthcare staff to come and see him in his cell. At approximately 1.45pm he was visited by a nurse. The man said he was feeling very unwell since he had started the antibiotic treatment and asked if a doctor could come over and see him. The nurse said that she would arrange for the doctor to visit the man in his cell the following day. The nurse left the man's cell but returned at approximately 2.10pm only to be met by wing officers who told her that the man needed to be seen immediately because he had collapsed on the floor.

28. The nurse reported that when she arrived at the man's side he was mentally alert, but that he was not able to move. A doctor and ambulance were called. When the doctor arrived, he examined the man and thought that he might have suffered some sort of spinal injury. Both the nurse and the doctor assisted paramedic staff to place him onto a spinal board for transfer to hospital.

29. When the Investigator spoke to the man's cell mate, he said that approximately two months before his death the man had started showing signs that he was unwell. The man had told him that there was blood in his urine and he had noticed that his skin was looking yellow. The man's cell mate said he was extremely concerned about him and he had asked a member of healthcare staff to visit him in the cell. The man's cell mate told the Investigator that he believed the man had faked the collapse in his cell to get the attention of prison and healthcare staff.

30. On two occasions, the man's hospital appointments were cancelled due to a lack of prison escort staff. The clinical reviewer has commented that even though the appointment dates were changed, he was still seen within NHS waiting time targets.

31. The clinical reviewer was informed by healthcare administration staff that this was a regular occurrence at Brixton. The decision regarding which appointments were cancelled appears to lie with the healthcare administration team. It is an unfortunate fact of prison life that, due to pressure on operational staff, hospital appointments may need to be re-scheduled.

However, we share the clinical reviewer's concern that the decision regarding which appointments are re-scheduled is made by healthcare administration staff, without any consultation with the prisoner's GP or the Head of Healthcare. We therefore make the following recommendation:

The Head of Healthcare should ensure an appropriate and clinically informed approach to prioritising external medical appointments in the event of insufficient escort staff for all appointments.

32. During the interview with a prison doctor he expressed concern that he was not informed that the man had died, despite being involved in his medical care. The doctor only became aware of his death when he was asked to attend an interview with the Investigator and clinical reviewer. The management of the man's medical condition has raised a number of issues. It is of concern that healthcare staff involved in his care were not given the opportunity to discuss his case during a clinical debrief. Such meetings should be routine and would ensure that any learning is captured effectively.

Following the death of a prisoner a clinical debrief should be held to allow healthcare staff involved in their care the opportunity to discuss the case and to identify future learning.

The diagnosis of the man's terminal illness

33. On arrival at Brixton, the man was identified as being dependent on heroin and cannabis. He was regularly seen by the substance misuse team and successfully underwent a detoxification programme.

34. The clinical reviewer considers that the man's diagnosis of hepatitis C was largely over looked by healthcare staff. Had he been referred for more specialist input into his condition, his care plan may have looked quite different. It is clear that there was a lack of a co-ordinated approach into the man's healthcare needs.

35. During the afternoon of 8 September, a nurse visited the man in his cell. She concluded that he was too ill to go and see the doctor and intended to arrange for a doctor to visit. However, before this could happen he collapsed in his cell. He was taken by ambulance to outside hospital.

36. Initially, the man was treated as though he might have a spinal injury, but this was eliminated after further tests. On 9 September, he had an ultra-sound and over the next few days underwent further blood tests. He also had a CT scan (a CT scan, or computerised tomography scan, is a special kind of x-ray - it shows far more detail than an ordinary x-ray image). On 12 September, he was told that he had a tumour on his liver and it was this that was causing him to be jaundiced.

Informing the man about his condition and treatment

37. The man was told the news of his diagnosis on 20 September by doctors and nurses at outside hospital. This was entirely appropriate as he was by this time an inpatient at the hospital. They gave him information about the tests that had been done and the results they showed, as and when they became available. It was the responsibility of NHS staff to keep him fully informed of developments in his care, and there is no evidence to suggest that they did not discharge this responsibility fully.

38. There is evidence to suggest that hospital staff arranged for palliative care specialists to visit the man, and it is likely that it would have been those staff that explained in more simple terms what his condition was. (Palliative care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other associated problems).

39. Within the bedwatch log, there are a couple of entries that suggest the man became upset when he realised that he was terminally ill. It is reported in that log that he particularly did not want to die without seeing his mother.

40. There are also some entries in the man's clinical notes that demonstrate staff at the prison were aware of the seriousness of his condition, although it is unclear from the records whether any of them spoke directly with him at this time in regards to him being terminally ill.

The man's pain relief, medication and palliative care

41. The man complained of a variety of symptoms to medical staff at Brixton between December 2009 and September 2010. From July 2010, he consulted healthcare staff more frequently and reported symptoms of discomfort in his groin and testicles, blood in his urine, episodes of vomiting and generally feeling unwell. As mentioned previously, although various tests were carried out on him and outside hospital consultations arranged, it was not until his admission to hospital that the cause of his symptoms was identified. His pain management was therefore dealt with exclusively by outside hospital.

42. It is evident from the bedwatch logs that, from his admission to hospital on 8 September, staff at the hospital struggled to deal with the man's pain. They tried a number of different pain relief medicines, and sometimes these would successfully control his pain, but at other times they could not. This may have been in part hampered by the process of tests and evaluation of his condition initially. On 16 September, a member of staff noted that the man was 'resisting taking analgesia'.

43. However, from the time that the man was diagnosed with cancer on 20 September, and the palliative care services became involved, it became a priority of the hospital staff to manage his pain.

44. On 2 November, the man went to a hospice with the express aim of improving his pain control.

45. It is evident from the prison's records and the bedwatch log that there was regular liaison between staff at the hospital and healthcare staff at the prison and that, in the main, efforts were made to keep the prison informed of the plans to manage the man's pain and to arrange appropriate end of life care.

Liaison with the man's family

46. The man's family asked the Investigator why they were not told when their relative first arrived at Brixton. During the induction process, prisoners are provided with the facilities for writing letters and encouraged to use the telephone. This enables them to maintain and strengthen ties with their families and the outside world.

47. Following the man's admission to hospital, there is an entry in the bedwatch log book by an officer that says that the man was asked who his next of kin was (which he confirmed to be his mother). However, he made it clear he did not want her to be contacted at this time but did not give any reason for his decision.

48. The man asked escorting staff on 14 September if they could arrange for him to have some money to buy some things from the hospital shop and enquired about contacting his family. This information was passed back to the prison. On 15 September, he asked a manager who was undertaking his management check on the escort arrangements the same things and the manager told him he would arrange it for the following day. Later that evening the man was given £15. It is not clear if he discussed his desire to contact his family with the manager but the bedwatch log indicates that he spoke with his mother on the telephone on the morning of 17 September.

49. There is no specific record of the hospital staff contacting the man's family at this point, nor is there any record of someone from the prison contacting his family. It appears contact was left to him and no direct record of what he told them exists. It is evident that the officer made a note in the bedwatch log of 24 September which says:

> 'In addition the consultant advised him [the man] to get in touch with his family and they can take it from there.'

50. Towards the end of the man's life, his brother became the main point of contact for family support. The community team at outside hospital assisted the family by arranging accommodation so that members of his family could come down from Scotland. This enabled them to spend several days with him.

51. During these times there was little or no restriction on who could visit the man, or on when or how long they could visit. It appears from the logs that it was not unusual for the man's brother to be with him for many hours in a day and

sometimes quite late into the evening. The man's brother was also present when he passed away in the hospice.

The man's location

52. Following the man's admission to the Accident and Emergency department at outside hospital on 8 September, his location within the hospital was decided by medical staff there.

53. Prison staff undertook regular risk assessments on the locations of the man, but it does not appear from the records that there was ever any conflict between prison and hospital staff as to the suitability of location or accommodation for him. A discussion took place between staff at the hospital and healthcare staff at Brixton on 5 October about the possibility of him returning to Brixton as it was the view of healthcare staff that appropriate palliative care could be provided for him at the prison. However, on the following day hospital staff advised that he had developed a chest infection and that hospice care was now being considered for him.

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Compassionate release

54. PSO 6000- Parole Release and Recall, Chapter 12 advises that early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is only granted in exceptional circumstances.

55. The fundamental principles underlying the approach to early release on compassionate grounds are:

- The release of the prisoner will not put the safety of the public at risk.
- A decision to approve release would not normally be made on the basis of facts which the sentencing or appeal court was aware.
- There is some specific purpose to be served by early release.

56. Early release may be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits but three months is considered to be an appropriate period. A clear medical opinion on life expectancy is required. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family. The decision to release a prisoner on compassionate grounds is made by the Secretary of State taking into account information provided by Prison Service staff and medical opinions.

57. The man was only formally assessed for release on temporary licence (ROTL) once and that was part of the routine hospital risk assessment process when

he was moved to a hospice. On 2 November, the Head of Security at Brixton made the decision on behalf of the senior management team that temporary release should not be authorised, but that restraints could be removed from him, with two members of staff present.

58. The man's family were concerned that he was not moved to a hospice nearer to their home in Glasgow. During an interview with the Investigator the Deputy Governor of Brixton said that at no time did the prison receive a formal request from the man to return to Scotland. He said that a letter was received from a Member of Parliament who he assumed was the representative for the man's local area in Glasgow. The Deputy Governor was unable to provide a copy of the letter or to detail approximately when it was received. However, we believe that the letter actually came from a Member of the Scottish Parliament.

59. The Deputy Governor said the letter requested that Brixton looked into repatriation. In response the prison explained that this would be extremely difficult to arrange because custodial warrants for England and Wales are not valid in Scotland. In addition, the local PCT would have had to take responsibility for the man's medical care.

60. It appears from the records that hospital staff also raised the possibility of moving the man to a hospital in Scotland with prison staff. This conversation took place on 5 November, when he briefly returned from the hospice to outside hospital for medical treatment. It was explained to the hospital staff that approval would need to be sought from the Justice Departments in Scotland and England and that gaining permission for such a transfer would in all likelihood have been a lengthy process. This was further complicated by the man's medical condition, although doctors felt confident that the physical challenge of travelling was possible for him, certainly up until 26 November.

61. The man was never formally assessed for compassionate release. However, it is understood that informal consideration was given before he was moved to a hospice. He was convicted of a violent offence and had a long history of offending. This included offences committed whilst on bail and failure to surrender to court. However, given the circumstances of his deteriorating health, it is considered that a formal assessment of his suitability for release on compassionate grounds should have been undertaken. It is also of concern that no formal record was kept of the correspondence between the Deputy Governor and the member from the Scottish Parliament. It is therefore difficult to assess the level of consideration given to the man's repatriation.

The Governor of Brixton should ensure that prison staff are aware that prisoners who are suffering from a terminal illness should be formally assessed for release on compassionate grounds. Any information relating to such an assessment should be formally documented.

Restraints, security and bed watch

62. The man's family raised concerns about the way in which he was restrained when at hospital and the hospice. They wanted to know whether the arrangements were appropriate for someone as ill as this man. When he was first taken to outside hospital on 8 September, he was the subject of an initial risk assessment that required he be escorted by two members of staff and that he should remain handcuffed to one of them at all times. The only exception to this would be if certain medical procedures needed to be performed that might put escorting staff at risk or would otherwise hamper medical staff. Such an exception occurred on 8 September when staff were asked to remove the handcuffs to facilitate the taking of blood and again on 10 September when he had a CT scan.

63. This initial risk assessment was reviewed within 24 hours of the man's arrival at the hospital and a more thorough, in depth risk assessment was undertaken. The Head of Security confirmed that the original instructions should more or less stand, except that handcuffs could be replaced with an escort chain. An escort chain is used to provide prisoners with a range of movement when they are confined to a hospital bed.

64. On 8 October, a review of the man's risk assessment was made which concluded that physical restraints could be removed from him, but that there should be two staff present at all times. On 2 November, he was moved to a hospice. A full risk assessment was made, including consideration of whether he should be released on temporary licence. It was decided to keep him unrestrained, with two officers present at all times, and that he should not be released on temporary licence. The prison did, however, allow him to have his clothing brought to the hospice, because all the patients used to eat together in their normal day clothes (rather than in pyjamas).

65. Just six days later, on 8 November, the escort arrangement was reduced from two members of staff to one member of staff. His risk assessment was reviewed on 29 November because he had started hallucinating and had been inappropriate in his behaviour towards female staff. The escort instructions were amended so that, where possible, only male staff would be on escort duty. Following deterioration in his health escort staff were withdrawn from his bedside. He died with his brother by his bedside. We are satisfied that the level of restraints was appropriate and he was treated in a dignified and respectful manner by bedwatch staff.

Other issues relating to the investigation into the man's death

66. During the course of the investigation, the clinical reviewer identified a prison doctor as a member of healthcare staff who had played an important role in the management of the man's medical needs. The doctor was first invited to interview on 16 March 2011. The doctor did not confirm her attendance at the interview despite repeated attempts by the prison's liaison officer. In the event she did not attend.

67. The Investigator discussed this matter with the Governor of Brixton. He asked the Investigator if consideration could be given to providing the doctor with another opportunity to be interviewed. The Investigator wrote to the doctor on 17 March with a suggested date for the interview as 30 March. The doctor told the liaison officer she did not wish to be interviewed and would therefore, not be attending.

68. PS0 27/2010- follow up to deaths in custody, advises at paragraph 6.1:

"All deaths in prison custody are subject to:

- A police investigation (on behalf of the Coroner and, if necessary, a criminal investigation)
- An investigation by the Prisons and Probation Ombudsman
- A Coroner's inquest before a jury

Staff must co-operate fully with these processes. This includes those staff not directly employed by the Prison Service, and also those who are working within an establishment or headquarters, on a contract or on a temporary basis, such as a locum doctor."

69. It is most concerning when a member of staff refuses to be interviewed as part of an independent investigation into a death in custody. The doctor's decision meant that the Investigator and clinical reviewer were unable to ask specific questions regarding the management of the man's medical care. Whilst most prison and healthcare staff agree to fully cooperate with an investigation it is unacceptable that this doctor refused to do despite the instruction of the PSO. We therefore make the following national recommendation:

The National Offender Management Service and the Department of Health should issue instructions to ensure that all staff working in prisons are aware of the mandatory instructions contained in PSO 27/2010, in particular that staff should fully co-operate with a death in custody investigation.

CONCLUSION

70. The man arrived in Brixton on 5 September 2009. He underwent a drugs detoxification programme which he completed in July 2010. Despite receiving a positive diagnosis for hepatitis C, he was not referred to a hepatologist until September 2010. The clinical reviewer has concluded that if the man's hepatitis C had been reviewed by a specialist when he first arrived at Brixton his care plan may well have looked very different. In essence, there was a clear lack of co-ordination between healthcare staff when managing the man's medical needs.

71. Following his collapse in his cell, the man was taken to outside hospital where he later received a diagnosis of liver cancer. When his condition deteriorated he was moved to a hospice for palliative care. The man's family expressed concern that he was not considered for a move closer to their home in Glasgow. The Deputy Governor told the Investigator that informal consideration was given to repatriation but this would have proved too difficult. The man's suitability for release on compassionate grounds was not formally assessed.

72. The man was treated in an appropriate and dignified manner by bedwatch staff during the final stages of his life at the hospice.

RECOMMENDATIONS

1. Prisoners who have a diagnosis of any long term or chronic condition should have an appropriate care plan, including referrals for specialist care as appropriate.

   Accepted

   All prisoners who have long term or chronic conditions have a care plan in place. As part of clinicians' assessments and delivery of care each patient needs to have their care package designed to facilitate appropriate discharge of care. A care plan is designed in direct consultation with a patient when it is required. Care plans are fully documented on SystmOne (patient record system) and should articulate the care to be discharged and the frequency by which certain interventions are carried out. Where a patient refuses or declines any intervention and where they are deemed to have full capacity to refuse or decline, patient choice is respected and clinicians cannot force patients to undertake the treatment interventions. All referrals are captured on SystmOne and hospital discharge letters accompany patients upon hospital discharge and these are in turn scanned on SystmOne against the patient's notes. There is a documentation audit which is undertaken annually where clinicians' documentation is audited, however it doesn't specifically look at care plans alone but the Lead GP randomly audits clinicians' assessments and management plans and any concerns are flagged through the incident reporting process.

2. The Head of Healthcare should ensure an appropriate and clinically informed approach to prioritising external medical appointments in the event of insufficient escort staff for all appointments.

   Partially accepted

   From a healthcare perspective there is a system in place where all escorts are prioritised by senior nurse and a GP in order of clinical risk. The administrative team also liaise directly with the referral hospital about rescheduling appointments where required and this is undertaken following clear instructions from the senior clinicians. Healthcare liaises with Oscar 1 about hospital escorts and decisions about prioritising escorts are made on the basis of available resources.

3. Following the death of a prisoner a clinical debrief should be held to allow healthcare staff involved in their care the opportunity to discuss the case and to identify any future learning.

   Accepted

   Usually following a DIC in the prison there is a hot de-brief held and chaired by the Prison Governor where all staff members involved with the patient/ prisoner's care are invited. In healthcare similarly the Head of Healthcare holds a clinical de-brief where clinicians retrace the patient journey and identify any quick lessons learnt pending full investigation. Additionally each morning in the Head of

Healthcare's brief there is a standing complexity agenda item where complex cases are discussed. This action will be enforced irrespective of whether the patient died whilst out at hospital or in prison.

4. The Governor of Brixton should remind prison staff that prisoners who are suffering from a terminal illness should be formally assessed for release on compassionate grounds. Any information relating to such an assessment should be formally documented.

   Accepted

   A note to SMT members has gone out.

5. The National Offender Management Service and the Department of Health should issue instructions to ensure that all staff working in prisons are aware of the mandatory instructions contained in PSO 27/2010, in particular that staff should fully co-operate with a death in custody investigation.

   Accepted

   Prison Service Instruction 64/2011 replaces PSO 2700 Suicide Prevention and Self-harm Management, PSO 2750 Violence Reduction, and PSO 2710 Follow Up to Deaths in Custody. The PSI supports the 'Management of prisoners at risk of harm to self, to others and from others' Specification and sets out the NOMS framework for delivering safer custody procedures and practices to ensure that prisons are safe places for all those who live and work there. Included in Chapter 12 is the mandatory action Staff must co-operate fully with all investigations following a death, including those by the police, the Prisons and Probation Ombudsman (PPO), the Health and Safety Executive (HSE) where applicable and the coroner's inquest.