Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Grant a prisoner at HMP Whatton on 29 December 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alan Grant died from lung cancer that had spread to other parts of his body, on 29 December 2016, while a prisoner at HMP Whatton. He was 71 years old. I offer my condolences to Mr Grant's family and friends.

I am satisfied that Mr Grant received a good standard of care and support at Whatton, equivalent to that he could have expected in the community. However, I am concerned that the security risk assessments justifying the use of restraints on Mr Grant for his hospital visits were poorly completed and did not take proper account of his failing health. I also consider that the prison should have processed an application for compassionate release with greater urgency. It is disappointing to have to raise these matters with the prison again.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2017**

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Summary

Events

1. Mr Alan Grant was a life-sentenced prisoner. In 2011 and 2012, while living in the community on licence, he had received treatment for throat cancer and lung cancer. After his recall to prison in June 2014, he refused to attend hospital appointments. He had been at HMP Whatton since 30 September 2015.

2. In February 2016, Mr Grant reported fatigue, coughing and breathlessness to a prison GP. Blood tests revealed abnormalities, so the doctor referred him urgently to a specialist. Further tests indicated a possible recurrence of cancer in Mr Grant's right lung and doctors planned to operate. However, in August, his consultant decided that he was unsuitable for surgery because the cancer had spread.

3. Mr Grant began palliative chemotherapy on 28 November and healthcare staff held multidisciplinary meetings to plan his care. They monitored him closely, managed his pain and provided medical aids. Mr Grant stopped chemotherapy on 21 December, as he felt too ill to continue. He died on 29 December.

Findings

4. We agree with the clinical reviewer that Mr Grant generally received a good standard of clinical care at Whatton, equivalent to that he could have expected in the community. A prison GP referred him to a specialist promptly when he reported worrying symptoms. In consultation with specialists, healthcare staff put in place appropriate care plans to meet Mr Grant's physical and emotional needs.

5. In spite of Mr Grant's impaired mobility and risk assessments that concluded that he was a low risk of escape, two escort officers accompanied him to hospital appointments, using either single handcuffs or an escort chain. We are not satisfied that all the decisions to use restraints took full account of Mr Grant's poor health and frailty and how this affected his risk of escape.

6. Although Mr Grant enquired about early release on compassionate grounds after receiving a terminal prognosis in August, the prison did not start an application until late December. There was also a delay in appointing a family liaison officer. Managers have since reminded staff of the importance of doing so promptly.

Recommendations

- The Director and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on 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.
- The Governor should ensure that applications for early release on compassionate grounds are completed and progressed promptly; and that staff assessing risk for such applications make a distinction between the risks posed by prisoners when fit and their risk when suffering from a terminal condition.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact her.

8. The investigator obtained copies of relevant extracts from Mr Grant's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Grant's clinical care at the prison.

10. We informed HM Coroner for Nottinghamshire of the investigation who gave us the cause of Mr Grant's death. We have sent the coroner a copy of this report.

11. The investigator wrote to Mr Grant's next of kin to explain the investigation and to ask if they had any matters for the investigation to consider. They did not respond to our letter.

12. The investigation has assessed the main issues involved in Mr Grant'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.

13. We shared the initial report with the Prison Service and they found no factual inaccuracies.

Background Information

HMP Whatton

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

15. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week. GPs from a local practice provide specialist clinics for older prisoners and those with chronic conditions and there is an out-of-hours service. There are no inpatient beds, but there is a palliative care suite in the healthcare centre, called The Retreat, for end of life care.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Whatton was in August 2016. Inspectors reported that the quality of health and social care was good and waiting times for treatment were reasonable. They found that a mix of appropriately skilled staff, in well-integrated teams, provided health services with polite and professional interactions. There was high demand for routine hospital appointments, though an increase in the number of available escort officers had significantly reduced the number of cancellations. They described the palliative care unit as excellent.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB reported that 37% of the prison's population were older prisoners. They said this was a severe drain on prison resources and the healthcare department struggled to manage the variety of complaints and conditions. They considered that the healthcare facilities were not fit for purpose and compared badly with those in the community. In the previous year, a business case to improve physical healthcare facilities was unsuccessful as funding was not available.

Previous deaths at HMP Whatton

18. Mr Grant was the 11th prisoner to die from natural causes at Whatton since January 2015. There has been a subsequent death from natural causes. We have previously raised concerns about shortcomings in the completion of risk assessments for hospital escorts and applications for compassionate release.

Findings

The diagnosis of Mr Grant's terminal illness and informing him of his condition

19. Mr Alan Grant was sentenced to life imprisonment in 1985 for sexual offences. He was later released on licence. While living in the community, Mr Grant had surgery for throat (tonsil) cancer in 2011 and lung cancer in 2012, followed by chemotherapy and radiotherapy. After his recall to prison on 6 June 2014, he declined hospital appointments to monitor for any recurrence of his condition, so his oncologist at hospital discharged him on 7 May 2015.

20. On 30 September 2015, Mr Grant transferred from HMP Lincoln to Whatton. At his initial health screen, a nurse recorded Mr Grant's previous history of cancer and that he was fit and well. He did not want to stop smoking. On 27 October, a prison GP noted that Mr Grant had declined follow-up oncology monitoring, as he felt that he had no medical problems and did not want to go to hospital in restraints. He intended to resume appointments after his release, which he expected to be in 2016. She explained the risks and that he could change his mind in future. She considered Mr Grant had the mental capacity to understand the implications and had made a fully informed choice.

21. On 4 February 2016, a prison GP examined Mr Grant after he reported weakness, lethargy, coughing and shortness of breath. He prescribed antibiotics and requested blood tests. On 12 February, he noted that the blood test results were very abnormal and scheduled an urgent GP review.

22. A prison GP examined Mr Grant on 16 February and suspected a recurrence of lung cancer. With Mr Grant's agreement, the doctor immediately referred him to hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The next day, the prison's cancer support nurse introduced herself to Mr Grant to discuss his immediate needs. She continued to support him over the following months.

23. Owing to a hospital error, there was a delay in Mr Grant receiving an appointment. On 11 March, he saw a specialist registrar in respiratory medicine, who confirmed that chest X-rays and a CT scan had revealed a mass in his right lung, indicating a probable recurrence of cancer. She arranged a PET scan (which shows detailed three-dimensional images) and a bronchoscopy, which took place on 30 March.

24. On 5 May, a consultant thoracic surgeon assessed Mr Grant and planned to remove tissue from his lung. Due to a misunderstanding between healthcare staff and the prison's pharmacy, Mr Grant was unable to have the surgery on 1 June, as the pharmacy could not supply an essential pre-operative blood thinning injection. Healthcare staff apologised to Mr Grant and his partner and rebooked the appointment. They also issued new instructions to staff on the process for pre-operative treatments.

25. On 1 August, the consultant thoracic surgeon told Mr Grant that he was no longer suitable for surgery, as another PET scan had shown new tumours in his lung and that the cancer had possibly spread to his hip.

26. We are satisfied that there was no delay in seeking a diagnosis after Mr Grant reported further symptoms. When he arrived at Whatton, reception healthcare staff considered referring him for specialist monitoring of his condition. A prison GP established that he had the mental capacity to decline treatment. We share the clinical reviewer's concern that Mr Grant missed surgery due to miscommunication about an important pre-operative injection and accept his view that the oversight did not affect the outcome for Mr Grant because the cancer was so advanced. The prison apologised to him and his partner and formalised the process for pre-operative care. We therefore make no further comment on this issue.

Mr Grant's clinical care

27. On 4 August, a consultant respiratory surgeon advised that she would consider Mr Grant for palliative chemotherapy, subject to further tests to determine his suitability. On 17 August, she reviewed Mr Grant and found that his cancer had spread. On 9 September, a bronchoscopy showed a large obstruction in his right lung.

28. In September, healthcare staff created palliative, nutritional and control of pain care plans. They monitored Mr Grant's pain daily and adjusted his pain relief with advice from his doctors.

29. Mid-October, a prison administrator contacted the hospital as Mr Grant was angry and upset that he was still waiting for biopsy results and had not received a follow-up appointment or definitive treatment plan. The hospital said that they would send an appointment once they had received the test results and held a multidisciplinary team meeting. On 13 October, Mr Grant told the cancer support nurse that he felt too unwell to go to the healthcare centre every day for his controlled medication. She offered to hold his cancer support sessions on his wing and arranged for staff to take his medication to him.

30. On 25 October, a prison GP wrote to Mr Grant's oncology consultant about tremors he had suffered for around four weeks, mainly when he was standing. Two days later, Mr Grant was admitted to hospital for assessment of the tremors. He returned to Whatton on 31 October. Staff continued to check progress on Mr Grant's outpatient appointment and he attended hospital on 16 November.

31. Mr Grant began palliative chemotherapy on 28 November. Healthcare staff gave him pre-chemotherapy medication and created additional care plans. They also held multidisciplinary team meetings to discuss his care. In early December, entries in Mr Grant's medical records noted that he appeared increasingly frail and was less mobile. On 8 December, he told an occupational health assessor that he had stopped chemotherapy, as it was not working (though the medical records showed that further chemotherapy sessions were planned). On 12 December, a prison GP ordered end of life drugs and a syringe driver to administer them, so they were available when needed.

32. On 13 December, a prison GP reviewed Mr Grant in his cell and explained that he might only live for a matter of weeks, or a few months at best. Mr Grant said he did not want anyone to resuscitate him if his heart or breathing stopped and she immediately signed an order to that effect.

33. The next day, Mr Grant felt too weak to attend his hospital appointment. Staff explained that if he did not go the hospital would have to cancel his next chemotherapy appointment. He accepted this and said that he was unsure whether he wanted to continue the treatment. Healthcare staff reviewed Mr Grant daily and he received formal carer support from 18 December.

34. On 21 December, Mr Grant decided to stop chemotherapy as it made him feel too ill and he knew that he was deteriorating. Although he wanted to attend his oncology appointment that day, he did not feel well enough to travel. In view of this, Mr Grant's consultant arranged an open appointment so the prison could rebook whenever Mr Grant thought he could manage the journey.

35. A nurse was with Mr Grant when he stopped breathing at around 10.35am, on 29 December. A prison GP confirmed his death at 1.30pm.

36. The Coroner accepted Mr Grant's cause of death as metastatic squamous carcinoma of lung (lung cancer that had spread to other parts of his body).

37. We agree with the clinical reviewer that Mr Grant was well supported by staff at Whatton and received a good standard of care, equivalent to that he could have expected in the community. Healthcare and hospital staff worked cooperatively during Mr Grant's palliative treatment and they communicated well with wing staff. Delays caused by the hospital do not fall within the remit of this investigation.

Mr Grant's location

38. Mr Grant lived on a residential wing throughout his illness. At an occupational therapy assessment on 8 December, healthcare staff offered him a hospital style bed, due to his increasing frailty. He declined, as he did not want to move to another cell to accommodate the bed. The assessor was satisfied that Mr Grant had the mental capacity to make an informed decision, but staff told him that if he had difficulty getting out of bed or needed assistance from others, they would insist on a move as a matter of safety. Staff assigned social care assistants to help Mr Grant. They also gave him suitable furniture and medical aids for his cell, as well as a wheelchair to go outdoors and to the wing telephone.

39. Mr Grant spent more time in bed as his mobility decreased. On 13 December, he was moved to another cell with a hospital bed. When he felt unable to go to the visits hall, staff arranged visits on the wing. On 24 December, prison managers authorised wing staff to keep Mr Grant's cell door open throughout the day and night, so that it would be easier for healthcare staff to monitor and treat him. Mr Grant became weaker and unable to move independently. Staff moved him to The Retreat on 28 December, where he died the next day.

40. We are satisfied that staff respected Mr Grant's wishes to remain on his wing for as long as possible. They made appropriate adjustments and moved him to the palliative care suite at an appropriate point.

Restraints, security and escorts

41. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment 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.

42. Mr Grant's health gradually deteriorated after August 2016. On 30 September, a medical record entry stated that his mobility was slightly limited. In October, he became weaker and could no longer attend healthcare for his medication. By November, he used a wheelchair to get around some parts of the prison.

43. Mr Grant had several outpatient appointments and a four-day hospital admission after his illness became terminal. All the security risk assessments concluded that his risk of escape, hostage taking, risk to the public and likelihood of outside assistance were low. There was little meaningful medical input in the risk assessments about Mr Grant's medical condition. Most of the healthcare entries omitted any reference to his use of a wheelchair and consisted of a brief annotation that there were no objections to the use of restraints and that his condition did not affect his risk.

44. Prison managers authorised two escort officers and the use of single handcuffs or an escort chain to restrain Mr Grant. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Some of the information recorded was contradictory. For example, on 28 November, managers instructed escort staff to use an escort chain due to Mr Grant's age and wheelchair use, yet the risk assessment on 5 December stated that he was not a wheelchair user and escort staff used single handcuffs.

45. The Head of Security told the investigator that she had recently raised the issue of risk assessments at multidisciplinary safeguarding meetings and the prison had revised the risk assessment form to remind staff of the appropriate factors to consider in assessing prisoners' risks. We are pleased to note the positive steps taken to raise staff awareness of the requirements. However, healthcare staff share the responsibility to complete full and accurate medical entries in the risk assessments and we are not satisfied that they fully understand the importance of providing substantive information on the impact of serious ill health on a prisoners' risk of escape, as the High Court judgment requires. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff completing and authorising risk assessments, justifying the use of restraints on 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 Mr Grant's family

46. Prison Service Instruction (PSI) 64/2011 states, "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the

next of kin or a nominated person of prisoners who are either terminally or seriously ill". Doctors diagnosed the recurrence of Mr Grant's cancer in March 2016 and informed him it was incurable in August. On 6 December, a nurse asked prison managers to allocate a family liaison officer (FLO) and one was appointed the next day. She introduced herself to Mr Grant on 12 December.

47. Mr Grant's partner was abroad at that time, so a friend acted as next of kin. During a visit on 15 December, the FLO met Mr Grant's friend. On 21 December, Mr Grant's friend said that he wanted to be with Mr Grant when he died, if possible, but if it happened quickly, the prison could telephone him. On the morning of 29 December, a prison manager informed Mr Grant's friend that he was likely to die that day and arranged for him to visit. Unfortunately, Mr Grant died a few minutes later before his friend had set off.

48. The prison paid the full costs of Mr Grant's funeral, which was held on 31 January.

49. We are satisfied that the prison's family liaison officer provided good support, but this should have been available to Mr Grant and his family sooner. In response to feedback given during the investigation, the Head of Safer Custody acknowledged the oversight. Since Mr Grant's death, he has reviewed the process and reiterated advice to relevant staff about the need to assign a family liaison officer as soon as they know that a prisoner has a life-threatening illness. We therefore make no further comment on this issue.

Compassionate release

50. 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 prisoners serving indeterminate sentences are set out in Prison Service Order (PSO) 4700. 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 HM Prison and Probation Service.

51. Mr Grant asked the cancer support nurse about compassionate release at a cancer support appointment on 15 September 2016. She advised him to ask his consultant for a prognosis at his next hospital appointment so that the prison could apply on his behalf. Entries in the medical records on 9 November and 8 December show that Mr Grant asked again about early release. On the latter occasion, an occupational therapist noted that it was "a lengthy process and unlikely to be completed in a timely manner". There was no evidence that either prison or medical staff sought a view on Mr Grant's life expectancy.

52. On 27 December an offender supervisor at Whatton completed the public protection section of an application for early release. (She explained that she was unable to complete the assessment sooner as she was on leave.) She did not support early release, concluding that Mr Grant remained at high risk of

reoffending because of his attitude towards his offences, previous breaches of licence conditions and other continuing risk factors, such as alcohol. When she spoke to Mr Grant on 28 December, he said that he wanted to consult his family later in the week before making a decision so she did not submit the application form to healthcare staff. He died the next day.

53. We do not know whether Mr Grant would have met the criteria for early release, such as adequate arrangements for his care and treatment. However, staff should have considered an application sooner, after his first request in September 2016. Additionally, as no supporting medical evidence was provided to the offender supervisor, the risk assessment did not consider whether Mr Grant's medical condition meant that his risk of reoffending was past, which is the appropriate test for early release on medical grounds. We make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds are completed and progressed promptly; and that staff assessing risk for such applications make a distinction between the risks posed by prisoners when fit and their risk when suffering from a terminal condition.

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