Investigation into the circumstances surrounding the death of a man at St Christopher's Hospice, whilst in the custody of HMP Wandsworth, on 8 November 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is a report of an investigation into the death of a prisoner at HMP Wandsworth. The man was released on temporary licence just before his death on 8 November 2010, at St Christopher's Hospice, London. He was 50 years old. I offer my sincere sympathy and condolences to his family, and all those affected by his loss.

One of my investigators conducted the investigation. As part of the investigation, a review of the man's medical care in custody was carried out by a clinical reviewer, on behalf of Wandsworth Primary Care Trust. I would also like to thank the Governor of Wandsworth and staff at Wandsworth for their co-operation and contribution during the course of the investigation.

Around 11 months after he went into prison, in late June 2010, the man reported abdominal discomfort. The prison quickly undertook further investigations and referred him to an outside hospital. He was admitted as an inpatient in early August and during that time, he was diagnosed with cancer of the pancreas. Around two weeks later, hospital staff told him that his illness was terminal. Although he returned to the prison, he was re-admitted to hospital as an inpatient on 7 October and died in a hospice just over a month later.

My investigation has highlighted that, overall, the man's clinical care at Wandsworth was good and it is clear that prison and hospital staff worked well together to provide both palliative care and other treatment when his health deteriorated. However, the processes for communicating with his family and securing early release did not go as smoothly. I therefore make two recommendations. One relates to visiting arrangements when a prisoner is in hospital. The two others relate to ensuring that staff are clear about communicating the most likely procedures for early release.

The original draft report was issued in June 2011. Unfortunately, after feedback was received from the Prison Service and the man's family, there was a delay in issuing the final report because of the long term ill health of the investigator. When the investigator returned, she found that the prison feedback pointed out that a member of staff had made a mistake when interviewed which had impacted on the findings of the report. Specifically, this related to one of the recommendations regarding the HDC process. The investigator has now clarified the issue and this has substantially changed this report. I have therefore taken the decision to re-issue it to give all interested parties an opportunity to comment on the revisions. I apologise for the delay and additional distress this may have caused.

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
Prison and Probation Ombudsman **February 2012**

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SUMMARY

1. The man was sentenced to three years imprisonment for drug offences on 29 July 2009. Almost a year into his sentence, on 23 June 2010, he first reported abdominal discomfort to healthcare staff at HMP Wandsworth.

2. Healthcare staff investigated the cause of the man's symptoms. At first it was thought that the discomfort was caused by his methadone prescription. This was then stopped, but the discomfort continued. He was subsequently referred to St George's Hospital where medical staff diagnosed cancer of the pancreas early in August. He remained in hospital as an inpatient until 27 August and during that time was told that his condition was terminal. Once he returned to Wandsworth, palliative care plans were put in place.

3. The prison notified the man's next of kin that he had been taken into hospital on 5 August and, because of the exceptional circumstances, the prison allowed his sisters to visit him on 6 August. (The prison policy states that prisoners who are in hospital cannot receive visitors until 36 hours have elapsed.) Unfortunately, after this visit the man's family found it difficult to arrange visits until his final admission to hospital in October. This is the subject of a recommendation.

4. The man's health continued to deteriorate and the prison began the process for early release on compassionate grounds (ERCG). This was stopped for two days because the process to release the man on Home Detention Curfew (HDC) was also in progress. Prison staff thought that the HDC would be suitable and the man would be released under this licence so they initially considered ERCG unnecessary. However, release under an HDC licence was unsuitable as it could not be effected while he was in hospital and he was too ill to return to the prison.

5. The ERCG process was then re-started. Due to the length of time it takes to process an application for ERCG and the man's deteriorating health, the prison considered release on temporary licence (ROTL). The Governor approved this on 1 November. The prison escort staff then left and the man remained in hospital until 3 November, when he was transferred to St Christopher's Hospice. He died five days later on 8 November, with his family around him. The prison offered financial assistance with funeral costs.

6. The clinical reviewer concluded that the care given to the man was appropriate and thorough and that prison healthcare staff communicated well with outside healthcare providers. We agree that the man's condition was diagnosed promptly and that his subsequent medical care and treatment were of a high standard. However, we make three recommendations, two relating to the arrangements for families when a prisoner is in hospital and one for the need for staff to have sufficient communication and knowledge of early release procedures and to consider the potential for deteriorating health whilst making these arrangements.

THE INVESTIGATION PROCESS

7. The investigation was opened on 9 November 2010, when the investigator visited the prison and interviewed two members of staff. She was provided with all the documentation relating to the man and visited the healthcare unit where he had spent some time. She also spoke to members of the healthcare team and was informed about the Jones Unit, a specialised ward for prisoners with long standing illness and palliative care needs. Notices were issued informing both staff and prisoners of my investigation. They asked anyone who had information pertinent to my investigation to contact the investigator, but no responses were received.

8. Wandsworth Primary Care Trust (PCT) provided a review of the medical care provided to the man while in custody. A clinical reviewer completed the review and subsequent report. We would like to thank him for his assistance. The final report was received on 23 May 2011.

9. The investigator wrote to the Coroner on 9 November 2010, to inform him of the investigation and request a copy of the post mortem report.

10. One of the Ombudsman's family liaison officers (FLO) wrote to the man's sister, his nominated next of kin, on 10 December. She explained the Ombudsman's role and the purpose of the investigation. The FLO spoke to the man's sister on 16 December, and she subsequently visited, with the investigator on 10 January 2011.

11. During the visit, the FLO and investigator explained the investigation process in more detail. The man's sister raised concerns about the quality of the prison's initial clinical assessments, the arrangements to hand in food at the hospital and the man's placement on the wing after his operation in July 2010. She was also keen for the investigation to explore problems relating to his home detention curfew (HDC) application, hospital visits and the use of restraints. These concerns are dealt with in the body of my report. We hope that it helps the man's family to understand what happened in the time leading to his death.

12. This investigation assesses the following aspects of the man's care and treatment:

    - Whether his diagnosis was made in a timely fashion.
    - Whether the man was told about his condition and the treatment which followed.
    - Whether he was treated properly and attended hospital appointments as necessary.
    - Whether the liaison with the man's family was appropriate.
    - Whether the man was accommodated in the most appropriate part of the prison.
    - Whether consideration was given to compassionate release from prison.
    - Whether appropriate palliative care was provided.

HMP WANDSWORTH

13. HMP Wandsworth, in South London is the largest prison in the United Kingdom. It holds up to 1665 male prisoners. The prison was built in 1851 and since 1989 it has undergone extensive refurbishment and modernisation. The prison has two main areas, Heathfield that comprises five separate wings and the Onslow Unit which houses vulnerable prisoners. In addition, there is a new healthcare unit with inpatient facilities, called the Jones Unit, which was opened in the summer of 2010. The man spent some time there before being taken to hospital. Although the Jones Unit provides inpatient facilities, it does not offer all the treatments available in a hospital. When prisoners become too ill they are admitted to an outside hospital.

14. In July 2007, Wandsworth Teaching PCT commissioned a private company, Secure Healthcare, to provide healthcare services at Wandsworth and employ the medical staff. However, the company went into liquidation in September 2009. The healthcare team is currently employed by St George's Hospital Trust. There is a full-time prison doctor, with general practitioner (GP) sessions taking place regularly on each wing as well as an out of hours service run by the local community service provider.

15. HM Chief Inspector of Prisons last inspected Wandsworth in June 2009. The inspection found that patients received thorough reception screenings, but there were gaps in the provision of healthcare. This included no immunisation clinics, staff vacancies on the primary care team and the cancellation of too many external appointments. Also highlighted was the lack of inpatient facilities for prisoners with physical illnesses and a recommendation was made regarding opening an inpatient unit. This was subsequently resolved when the Jones Unit opened in 2010.

16. The Independent Monitoring Board (IMB) is a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs for the public interest. They are not members of the Prison Service, nor are they part of the management team. They are required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern.

17. The Independent Monitoring Board (IMB) report for 2009-2010, identified similar concerns about the provision of Wandsworth's healthcare. It noted that:

    "in recent reports we have reported on an improving prison. This year we believe that for a number of reasons this change has been reversed, although there are areas where encouraging progress has been maintained."

18. The report acknowledged that a lack of information regarding hospital appointments (especially those that were cancelled) is a particular source of frustration and concern to prisoners. However, the Board added that senior nurses have been pivotal in maintaining standards of care and have responded promptly and professionally to emergencies.

19. Since 2004, when this office started to investigate all deaths in custody in England and Wales, there have been 11 deaths, including the man's, due to natural causes at HMP Wandsworth.

Early Release on Compassionate Grounds (ERCG) – Prison Service Order (PSO) 6000

20. PSO 6000 sets out the procedures for the permanent early release on licence of prisoners on compassionate grounds. It says that early release may be considered 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. The PSO stresses that it is essential to obtain a clear medical opinion on the likely life expectancy of the prisoner. The Secretary of State needs to be satisfied that the risk of re-offending has reduced and that there are adequate arrangements for the prisoner's care and treatment outside prison. Early release may also be considered when the prisoner is bedridden or severely incapacitated. This might include those confined to wheelchairs, paralysed or severe stroke victims. Applications may also be considered if further imprisonment would endanger the prisoner's life or reduce his or her life expectancy. As part of the application process the prison is required to obtain information from a number of sources including a medical officer and the prisoner's community offender manger/probation officer.

Home Detention Curfew (HDC)

21. HDC, also known as tagging, is a provision which allows some prisoners to be released early from prison. They are required to wear an electronic tag and they must be at a specified address during specified times. Prisoners must be risk assessed and have suitable accommodation approved by the Probation Service before they can be granted HDC.

The man

22. The man was born on 7 November 1960. He was addicted to illicit substances over a significant number of years and he had drug related previous convictions. On 29 July 2009, the man was sentenced to three years imprisonment. He was remanded to HMP Wandsworth where he attended various courses to address his substance misuse problem. The man chose not to receive visits from his family and friends during his sentence.

23. Prison and healthcare staff spoke well of the man. They described him as a man who was no trouble, who managed his sentence well and told my investigator that he was well liked by both prisoners and staff.

Issues

The diagnosis of the man's terminal illness

24. The investigator examined the man's medical records. In line with Prison Service policy, prison staff completed a first reception health screen following his arrival at HMP Wandsworth on 29 July 2009. This identified that he had a 30 year history of polysubstance (the concurrent misuse of two or more substances) use. At the healthscreen, he had various tests to identify any drugs he may have used prior to his remand at Wandsworth. The man was prescribed medication including methadone (a synthetic opiate) to relieve his withdrawal symptoms from drugs and he was referred to the prison's drug service. He also asked to see a prison doctor.

25. The man's appointment with the GP took place the next day. The GP noted that the man had mild to moderate opiate withdrawal symptoms and he increased the dosage of methadone. The doctor reviewed him two weeks later on 13 August, and summarised that the man was clinically stable. Between 21 November and 19 May 2010, healthcare staff assessed the man on five occasions. They reviewed his methadone prescription and also discussed a drug detoxification programme. (Detoxification is a process to rid the body of a drug whilst treating the symptoms of withdrawal.)

26. On 23 June, a substance misuse doctor assessed the man in respect of substance misuse. She described him as "very slim". For the first time, it was noted that he had "longstanding abdominal discomfort" together with some bloating and nausea when he ate and this needed investigating further. The man's weight at this time was recorded as 55kg.

27. A nurse consultant at the prison examined the man on 29 June in respect of the abdominal discomfort. The man explained that he had experienced lower abdominal pain for the previous two months and said that it got worse after he ate. He told the doctor that he had lost 10kg over the last 12 months and 4kg since his reception screening. In addition, he said his bowels opened infrequently and his appetite was poor. The nurse said that he believed that the man's methadone prescription was likely to cause constipation and could possibly be the cause of his abdominal discomfort.

28. The nurse also noted there were no reports of blood or mucus following bowel movements. On further examination, he found that the man then weighed 51.8kg and there were no "scars or masses" on his abdomen and it was not swollen. He asked for blood tests to be taken and an examination of the man's stools for helicobacter, bacteria, which causes chronic inflammation of the inner lining of the stomach. The man was also prescribed omeprazole (medication to treat heartburn and ulcers) and advised he would be reviewed again with the results. A medical laboratory report from St George's' Hospital on 2 July, shows that a specimen for the helicobacter test was taken on the same day and the result was negative.

29. A GP examined the man on 15 July. The man again reported the same concerns. However, he added that he was then finding it difficult and painful to swallow food. His weight was recorded and had increased to 52.3kg. He was also advised to eat soft solid food from the prison's menu. The doctor prescribed multivitamins and referred the man to the Genito-Urinary Medicine (GUM) Clinic to be checked again. In addition, blood, liver and kidney function tests were requested.

30. The doctor reviewed some of the man's test results the next day. He said that the thyroid (a gland that helps to regulate some of the body's functions), bone profile (test to measure composition of the bones) and renal (kidney) tests were all normal. He added that no action was required in respect to the blood and liver tests.

31. Around three weeks after the man's initial complaint about abdominal pains, he attended his appointment with a doctor from the GUM in-reach service on 22 July. The doctor told the man that he had been checked for hepatitis (inflammation of the liver), HIV (human immunodeficiency virus (HIV) damages the body's ability to fight illness and infection) and said he would be updated about his tests. The man repeated the information about his weight loss and abdominal pain. The doctor noted that the man looked pale and "cahexic". (Cahexic is a term used to describe weight loss and a deterioration in a person's physical condition.) He queried whether there was an underlying neoplasm (abnormal growth or tumour). The doctor organised an urgent abdominal ultrasound scan (a procedure to obtain pictures or images from inside the body) and a chest x-ray.

32. A member of healthcare team saw the man on the wing on 28 July. He had continuing gastric (stomach) discomfort and described an obstruction when he swallowed. He said that the omeprazole had not relieved his symptoms and was subsequently prescribed Gastrocote (another medication to treat heartburn).

33. The following day on 29 July, a GP reviewed various test results and recorded that they were either normal or no action was required. However, in relation to the liver function results he diagnosed progressive cholestasis. (Cholestatsis is a condition in which the flow of bile from the liver is blocked.)

34. Another doctor conducted a review later that day. The man told him that he was no longer taking methadone but his condition had not improved. The doctor advised him to continue to take the vitamins. He also prescribed mebeverine hydrochloride (a medication to relieve the pain and discomfort associated with stomach spasms).

35. On 30 July, healthcare staff at Wandsworth received the results of the man's scan and x-ray, which concluded that there was a blockage in his intestine, which could be caused by cancer. An urgent Computed Tomography (CT) scan of the man's stomach and pelvis was arranged for the same day, which also indicated a mass in the intestine and enlarged nymph nodes. (A CT scan gives detailed images of the inside of the body.) This was also considered as a potential indication of cancer and an urgent referral under the two week rule was made by

a doctor on 2 August. (A two week rule was introduced by the National Health Service to ensure that patients with suspected cancer see a specialist within 14 days of an urgent referral by a doctor.)

36. On 4 August, a staff nurse examined the man and described him as “pale and weak”. His condition had deteriorated and he was subsequently admitted as an emergency to St George’s Hospital, where further tests were carried out and a diagnosis of cancer of the pancreas was made. The man had an operation to have a biliary stent fitted. (A biliary stent is a plastic or metal tube that is inserted into a bile duct to relieve the narrowing of the duct.) He was also referred to The Trinity Hospice for palliative care. (Palliative care is a specialised area of healthcare which focuses on relieving and preventing the suffering of patients. It uses a multidisciplinary approach to address physical, emotional, spiritual and social concerns that arise with advanced illness.)

37. The man first complained about stomach problems on 23 June and was diagnosed with cancer early in August, less than two months later. When his symptoms did not get better he was referred appropriately. The clinical reviewer stated that the diagnosis of cancer of the pancreas is “nearly always difficult” to make in the early stages. This is because patients are usually “asymptomatic” (no symptoms) or have “very non-specific symptoms”. He adds that it is common for patients to be finally diagnosed at “quite a late stage”. The clinical reviewer commented that the man’s presentation and diagnosis of cancer of the pancreas is “sadly a typical presentation” of this disease. He concluded that the investigation and management of the man’s condition seems to have been “quick, thorough and efficient”. We note the extent of the investigations to diagnose the man’s illness and concur with the clinical reviewer’s conclusion.

Informing the man about his condition and treatment

38. The National Institute for Health and Clinical Excellence (NICE) issued referral guidelines in 2005 for suspected cancer. It highlights the information that should be given to patients who are referred to a specialist with suspected cancer. In August, Wandsworth’s bed watch history log shows that the man was told of his diagnosis, although it was unclear when this took place and who gave him this information. (If a prisoner is admitted to an outside hospital, depending on the risk assessment carried out by the prison, they will generally be escorted by two officers who will stay beside their bed at all times. This is known as a bed watch. The log is a history recorded by escort officers, of time and events which take place while the prisoner remains an inpatient.) Although the investigator asked healthcare staff who had informed him, staff were unable to clarify this. However, on 8 August, the man told a bed watch officer that he was “glad” that the doctors had diagnosed him finally.

39. The bed watch log also indicates that the man had appointments with a number of specialists in relation to his condition and treatment. On 11 August, a Macmillan nurse visited him. A senior nurse at the prison said that the job of the MacMillan nurse was to explain the diagnosis and treatment and offer support and guidance to patients.

40. The log shows that on 13 August a surgeon explained to the man they were unable to get to the tumour to operate on it. An oncologist (cancer specialist) also reviewed him four days later, and he was given leaflets about his condition. A specialist discussed with the man the possibility of chemotherapy (a treatment for cancer) as well as other options. They also explained to him that his tumour was inoperable and the primary objective was therefore to enable him to consume food.

41. Whilst the man resided on the Jones Unit, he was offered support from the senior nurse and other healthcare staff. Another nurse asked him whether he wanted to see a counsellor and this was offered again to him on 29 August and 9 September. However, on all three occasions the man declined this support. He spoke to the prison's duty chaplain and duty governor on 7 September. Furthermore, another prison nurse said she discussed the man's diagnosis with him at length on 9 September.

42. At the end of September, the man told Wandsworth's healthcare staff that he had diarrhoea. As there was no improvement in his condition, he was admitted to St George's Hospital on 7 October. During the following week, clinical staff spoke to the man about chemotherapy and said he required further tests for a possible chest infection. On 19 October, he saw a hospital doctor and nurse who explained that his condition was terminal and his life expectancy was six months. They asked if he wanted to see the hospital's chaplain, but he declined. The man's sister had been visiting him at the hospital when he was given the news and she was permitted to stay with him for a few hours.

43. The clinical reviewer says in his clinical review that the man appeared to be involved in the management of his condition, including the support of the nursing, medical and palliative care team. He also draws attention to the early involvement of the palliative care team. We believe it was clear that the man was aware of his condition and prognosis throughout his illness and prison staff fulfilled their responsibilities in this regard.

The man's medical appointments and treatment

44. Staff at Wandsworth and St George's Hospital communicated regularly during the man's admission from 4 to 26 August. The prison senior nurse visited him on three occasions. She told my investigator that she spoke to the man to see how he was and also discussed the possibility of him being discharged to the Jones Unit at the prison rather than returning to the wing. She also liaised with hospital staff about the man's diagnosis, treatment and possible discharge plan.

45. When the man was discharged from hospital on 26 August, he was admitted to the Jones Unit. The electronic clinical record shows that the nurse transfer/discharge form from St George's Hospital was received on 3 September. This shows that he had pancreatic cancer and he was aware of the diagnosis. Details of his required care included monitoring his weight on a weekly basis, provision of supplements, Oramorph (pain relief medication), monitoring his food intake and a dietician review if he was unable to eat or drink.

46. A nurse examined the man on the day of his discharge from hospital. She noted that he had a bag of medication and a discharge prescription sheet. Arrangements were made for the latter to be written up by a prison doctor and a prison GP subsequently confirmed that this was done.

47. On 27 August, the senior nurse listed the man's requirements which reflected the details in the nurse transfer/discharge form from hospital. She also noted his recent surgery and that he was under the care of a palliative team. She made it very clear that it was a priority for the man to attend hospital appointments and said that his nutritional intake was to be strictly monitored and nutritional supplements were to be supplied. She also recorded that if the man was unable to tolerate prison food, the prison kitchen should be contacted to determine what could be reasonably provided.

48. Between 28 August and 5 September, the man's observations, such as his blood pressure, pulse and temperature were checked daily, as well as his weight. He was reviewed on four occasions by four prison GPs on 28 August, 1, 3 and 4 September respectively, but no concerns were noted. The man's diet was also monitored during this period. Two prison nurses discussed specific requirements with him on 31 August. The following day, one of them made arrangements with a senior officer based in the prison's kitchen, for the man to be provided with yogurt, ice cream and a carton of fruit juice on a daily basis.

49. The man attended his scheduled appointment for a scan at St George's Hospital in early October. When he returned to Wandsworth healthcare unit he continued to be monitored in line with the discharge plan. However, on 7 October the senior nurse noted that the man was very pale. She contacted St George's Hospital and discussed his condition with a palliative care nurse and he was subsequently admitted to hospital. During this time, staff at Wandsworth's healthcare unit kept in regular contact with St George's Hospital.

50. The man did not miss any appointments and indeed the senior nurse ensured, through the discharge form, that other staff were aware that he should be prioritised for any hospital appointments. In his review, the clinical reviewer comments that the care of the man was "appropriate and thorough". He also comments on the "commendable level of detail sharing of the care between the prison medical service and Trinity palliative care team". We concur with this view and note the efforts made by healthcare staff to ensure that the man's treatment corresponded to that in the care plan and that his nutritional requirements were sustained.

The man's pain relief and medication

51. Following the man's discharge from hospital on 26 August, he was prescribed buprenorphine patches and Oramorph (medications to treat severe pain). His clinical records show that when he complained about being in pain and asked for medication this was always given to him. The electronic clinical record notes that his medication was reviewed by a member of the palliative care team, from Trinity Hospice, on 7 September. She suggested that the dosage of some of his pain relief medication was increased.

52. On 20 September, a prison GP reviewed the man, who was upset that he was on Subutex as it had taken him years to detoxify from opiates. (Subutex is also known as buprenorphine and is used to treat the withdrawal symptoms from heroin.) He told the doctor that he had removed the patch the previous night when he was told what the medication was. The doctor had a long talk with the man and he explained the rationale for the use of the drug. Later that day, he discussed the man's medication with a palliative care nurse. It was agreed that the buprenorphine patches could be changed to fentanyl (treatment for severe pain caused when other painkillers do not provide sufficient relief) as the man might have fewer objections to this medication.

53. The following day, the senior nurse also discussed the buprenorphine patch with the man. He agreed to continue with it until the fentanyl was obtained. A member of the palliative care team from Trinity Hospice spoke to him on 29 September. She noted that a doctor would be consulted about changing the patch to fentanyl. On 1 October, a nurse recorded it had been changed, but the fentanyl patch was not available until after the weekend. This was almost two weeks after the man had asked for the medication to be changed.

54. The clinical reviewer states that the man's "medications were appropriately updated on discharge from hospital and his pain was well controlled." The man was understandably unhappy about the buprenorphine prescription; however at that stage it appeared to be the most appropriate medication for his pain relief. We are concerned that it took two weeks to change the medication and suggest that healthcare staff consider whether this could have been done sooner. Nevertheless, we agree with the clinical reviewer's view that overall the man's pain relief and medication was provided as and when he needed it and that it was effective.

Liaison with the man's family

55. HMP Wandsworth has a protocol which sets out the procedures for visits whilst a prisoner is in hospital and subject to bed watch procedures. The protocol says:

> "Unless there are exceptional circumstances approved by the Governor, prisoners will not be allowed visits for the first 36 hours. Once this time has elapsed and the risk assessment allows for visits, a prisoner may receive visitors once every 24 hours by those people on the approved visitors list only.
>
> "Security management will be responsible for informing the next of kin, the prisoner has nominated from his approved visitors list that he is in hospital, that they may visit him, the times when the hospital allows visits and the contact number at the prison to book a visit."

56. The man's sister told my investigator that she visited him after they received an initial telephone call on 5 August, notifying them that he was in hospital. The bed watch log confirms that an escorting officer was told by the prison's control department on 5 August, that the man's sisters would be visiting him on 6

August. This was less than 36 hours after his hospital admission and reflected the exceptional circumstances. The officer was also advised that the family had been “cleared” for security purposes. Two of the man’s sisters subsequently visited him on 6 August.

57. Following the first visit, the man’s sister said that his family realised that he was desperately ill and they wanted to see him on a daily basis. However, she said that each time they attempted to do so they were unsuccessful because they were not on the visitors’ list. The investigator made enquiries about this. The security records confirmed that on 9 August, five days after the man’s admission, the control room received a call from the man’s sister who was trying to book a visit. It was noted that she was not on his list of authorised visitors, although she told them she had been allowed to visit on 6 August. Security staff contacted the man’s bed watch escort staff and it was discovered that he had written a visits list and handed it to staff. However, there was no indication when this was done and the investigator could not find out what happened to the list.

58. On 12 August, the officer called the prison control room and spoke to a governor. He said that he would look into why the man’s sister could not book a visit. On the same day, another escorting officer wrote on the bed watch log that he told the man that his family would need to contact the visits booking department to arrange a hospital visit. This is at odds with the protocol.

59. One of the man’s sisters wrote to the prison’s social visits department on 12 August, asking to arrange a visit to him. In the letter she explained the difficulties she was having trying to book further visits after the one on 6 August and that she had telephoned numerous numbers to no avail. The following day, a third escorting officer said that control room told him that another prison manager had approved a visit from the man’s sisters to take place on 13 August, although they were still not on the authorised list. The bed watch and visits logs indicate that the man’s sisters visited him on a further three occasions on 15, 19 and 25 August and his uncle saw him on 26 August.

60. During the man’s second admission to hospital between 7 and 28 October, the bed watch and visits logs show that he was visited on ten occasions by members of his family. He was also permitted a telephone call from his aunt on 20 October. On the same day, one of his sisters forgot to notify the control room about the visit. However, an SO, the escort officer, allowed it to go ahead because he knew that she had previously visited. In addition, on 27 October, his sisters arrived late and the visit was initially declined but following a discussion with the duty governor it was permitted to take place.

61. HMP Wandsworth’s protocol says when individuals visit prisoners in hospital; they are not permitted to hand over any food, clothing or property. On 13 August, the escort officer said that the man’s sisters asked if they could give him clothing and books. This was refused according to the policy but when his sisters visited again on 24 October, they were allowed to give him a dressing gown and slippers.

62. A dietician assessed the man on 18 October, and recommended extra fluids such as Lucozade or flavoured water. Consequently, the SO spoke to another manager on the same day. She agreed that the man's visitors could buy the drinks identified by the dietician, but said she had to speak to bed watch staff first to establish what was allowed and purchase them from the hospital shop. The sealed item with a receipt could then be given to bed watch staff. On the same day, the man's sister bought him a bottle of Ribena. He also purchased some drinks using his own money.

63. On 27 October, a nurse told the escort officer that they were going to give the man an ice lolly, which had been left by his sister. The officer told the nurse that nothing was to be given to the man without the consent of a governor. Another officer explained to the nurse that under no circumstances were visitors allowed to "bring anything" without the permission of a governor.

64. The man's sister told the investigator that she was frustrated about the inability to hand in food for him, given the implications for his treatment. She explained that towards the end of his life all he could manage was an ice lolly which she purchased in a sealed packet. His sister found that there was a lack of a consistent approach because on some occasions this was allowed and on others it was not.

65. A Developing Prison Service Manager (DPSM) was allocated the role of prison family liaison officer on 18 October. This was the day before the man was told that he was terminally ill. Much of the DPSM's liaison with the man's family centred on making arrangements for early release on compassionate grounds and is outlined in the next section of this report.

66. The investigator asked the DPSM about the inconsistencies of the bed watch officers in respect of visitors providing property and food items. She replied that the policy was clear about giving anything to prisoners whilst they were in hospital and also explained that this was also for the safety of the prisoner himself. She said that whilst some officers allowed the family to give items to the man, this was at odds with the protocol and that the escort officer had applied discretion in this case.

67. The difficulties and delay that the man's sister had in arranging visits to her brother when he was so ill are unacceptable. Although certain governors at the prison gave permission on some occasions, it is regrettable that clarity was not given from the first visit. The man's sister said she rang various telephone numbers at the prison to arrange visits and was unable to make clear arrangements to visit her brother on a daily basis, as was her wish. Furthermore, the man apparently gave a list of visitors' names to an escort officer but this does not appear to have been processed. This caused a further delay in his family arranging visits. These issues caused the family additional distress at a time when they were also dealing with the potential loss of their brother. The arrangements should have been handled more efficiently and it is best practice to assign a family liaison officer, at the earliest opportunity, in such instances. We therefore make the following recommendations, in respect of bringing items

into hospital for a prisoner and arranging family visits to a prisoner who is in hospital.

The Governor should ensure that staff who escort prisoners at hospital are familiar with the policies and procedures in respect of visitors, as well as any specific instructions regarding an individual prisoner.

Prison staff should give clear written instructions to families, with an appropriate point of contact about arranging visits, security requirements and bringing in property for the prisoner.

The man's location

68. Following the man's discharge from hospital on 26 August, he was admitted to Wandsworth's healthcare unit. The details of his deterioration are documented below. Attempts were made to treat him at the prison, but as his condition worsened and particular treatments were required he was admitted to hospital.

69. When the man was nearing the end of his life he and his family wanted him to be at his sister's address and the next section discusses the issues that were raised when this was considered. In his last few days, hospital staff realised that the man needed more care than could be offered at home and with his agreement, he transferred to a hospice five days before he died.

Early release on compassionate grounds

70. The DPSM said that she received a letter from the man's sister on 14 October asking for consideration to be given to her brother obtaining early release on compassionate grounds (ERCG). On 18 October, a day before he was told his condition was terminal, the DPSM, the family liaison officer started the process to complete the risk assessments necessary for ERCG.

71. Initially, the DPSM told the investigator that when she started to liaise with healthcare and probation staff to agree an appropriate discharge address and risk assessment, she realised that the man had been granted HDC to his father's address from 20 October. She said that as she believed that the man was likely to be released under the terms of the HDC, it did not seem necessary to continue the procedure for ERCG. In feedback to the first version of this draft report, the DPSM explained that she had made a mistake when she told the investigator that the man had been granted HDC to his father's house as he had in fact been granted HDC to his sister's house. The man's sister said she was not aware of this at the time and was not told about the HDC until November. She was confused about the different licences and their limitations.

72. Unfortunately, during this period of time the man's health started to deteriorate more quickly. The DPSM said, in her feedback to the original draft report, that the hospital could not provide a date for the man to be discharged because of his deteriorating health. She explained, however, that if he could be discharged from hospital, he could go to his sister's address. The man's sister was never aware of this. He could not be released on HDC to the hospital because a

hospital cannot be used as a discharge address for HDC purposes. In the event that he was well enough to be discharged from prison, the DPSM explained to his sister that he would first have to be discharged from hospital to the prison, where he could then be released on HDC licence. However, the prison considered ways to avoid the man having to return to prison in order to obtain his HDC. For example, they planned for the family to collect the man as soon as he arrived back to the prison from the hospital, or for the prison staff to attend the hospital to carry out the discharge process.

73. As HDC could not be activated while the man was in hospital, the DPSM subsequently resumed the ERCG process and also started procedures for Release on Temporary Licence (ROTL). Prison Service Order 6300 sets out the Prison Service's policy for the release of prisoners on temporary licence. In certain circumstances, a prisoner can be released on temporary licence (ROTL) for compassionate reasons or to help the prisoner improve their chances of resettlement after their release. There is no maximum duration for such a licence where a prisoner is receiving in-patient treatment in hospital.

74. The DPSM explained to the investigator that the ERCG process often takes a long time. She said that information needs to be obtained from the health service with regard to treatment, prognosis and a suitable discharge address as well as information from the probation service, to conduct a full risk assessment. The DPSM estimated that this would take "more than a month" to complete.

75. At the time, the man was still in St George's Hospital and his sisters were very worried that he would not be granted ERCG. Health staff explained that he was too poorly to leave hospital at that time. They were in the process of making arrangements to transfer him to a hospice, with his and his family's agreement. Unfortunately a hospice, like a hospital, is not considered appropriate as a discharge address for HDC purposes. The DPSM continued with the ERCG application.

76. As the man's health deteriorated, his family remained very anxious about the prospect of him spending the last few weeks of his life bound by prison rules and escorting officers. Between 20 to 22 October, various communications took place. The senior nurse wrote to a prison manager to explain that the man was terminally ill and receiving palliative care. The specialist estimated that his life expectancy was a matter of a few months, but added that this was "probably single figures". The senior nurse added that the man was not well enough to withstand chemotherapy and the hospital consultant was preparing a letter outlining his poor prognosis. In an email to the prison manager, the senior nurse said that the issue of the HDC seemed to have been ongoing for some time and felt that the prison needed to act swiftly to speed up the man's release.

77. St George's Hospital also faxed a letter from a consultant oncologist to the senior nurse. It said the man had a diagnosis of adenocarcinoma which carried a very poor prognosis of 12 months from the point of diagnosis and it was not "very sensitive" to chemotherapy. (Adenocarcinoma is a type of cancer.) The consultant noted that he had been diagnosed in July. The consultant explained that the man had very specific palliative needs with regards to eating and pain

relief and there was concern that this "may not be best managed in prison". It was suspected that his health would continue to deteriorate. The consultant asked for early discharge on compassionate grounds to be considered.

78. The man's electronic contact log shows that at 8.34am on 28 October, he was granted ROTL to St George's Hospital, by the prison's Deputy Governor. The bed watch log notes that the escorting officers were notified and that other staff would attend to complete the process. The man was told about it and he was described as "happy". The bed watch log shows that at 10.18am, an officer arrived at the hospital and explained the ROTL conditions to the man. The bed watch procedures then stopped and the escort staff returned to the prison.

79. The man's family were concerned that given his rapid deterioration, HDC and delivery of the necessary medical equipment might not happen in time. One of the Macmillan nurses at St George's Hospital told the prison's family liaison officer that there were a number of professionals involved in the man's care and they all agreed that he was in the terminal stages of his illness. His prognosis at that stage was estimated at weeks. However, she said it was very difficult to predict and he could deteriorate more rapidly. He was now largely bed-bound, very weak and his oral intake was very limited. The man was clear that he did not want to die in St George's Hospital. The Macmillan nurse and the man's sister were concerned that he was deteriorating quickly and this could happen.

80. The Macmillan nurse suggested that the most likely options were either that prison staff attended the hospital to release the man to his sister's on HDC or that he was transferred to a hospice. The nurse, who acted as the liaison between the hospital and the prison, concluded that it was most likely that the man would be transferred to St Christopher's Hospice. She provided the address, although she explained that this had to be confirmed once he and his sister had been consulted. She added if everyone agreed with this plan the hospital would want to move the man as soon as possible. She gave a timeframe of between 24 hours and a few days and asked if the procedures for ROTL to the hospice could be started.

81. On 1 November, the DPSM said that before the man could be moved from St George's Hospital, a risk assessment of the hospice would need to be conducted. She added it was not simply a case of replacing one address with another. If it was deemed to be medically appropriate that he should go to St Christopher's before a ROTL could be authorised, he would be escorted by two officers, until the authority was given. She reiterated that for his ERCG to be progressed the prison required further advice from the man's consultant.

82. The details of the man's medical consultant were provided and the Macmillan nurse agreed to ask the doctor to provide the information for the ERCG. The risk assessment for St Christopher's Hospice was still outstanding and the man was deteriorating rapidly. He was considered to have only days to live and his preference was to go to St Christopher's Hospice.

83. The man moved to St Christopher's Hospice on 3 November, where he died five days later, on 8 November. His family were with him at the time and they notified

Wandsworth that he had died. In line with Prison Service Order (PSO) 2710 (the policy document that sets out the actions to be taken following the death of a prisoner), Wandsworth offered financial help towards the funeral costs but the family refused this assistance as they said they "felt it was a bit late to be offering" them help.

84. Unfortunately, the man died whilst the ERCG reports were still being collated. The DPSM said a number of licences were pursued at the same time because it was not clear where the man would be living following his discharge from hospital or which one was the most appropriate. Staff at Wandsworth made efforts to secure the man's release before he died. However, there were clearly difficulties establishing which was the most appropriate form of release for him because of his deteriorating health.

85. When the gravity of the man's illness and life expectancy became known, the prison started the process for a number of release plans and he was not subject to prison escorts in the last days of his life. Staff appeared to approach this diligently and conscientiously. However, the man's sister was always of the view that an HDC for her address had not been authorised. The senior nurse similarly commented that the HDC process seemed to be taking a lot of time. This ambiguity was time consuming and caused additional stress to the man and his family during the last stages of his life. We appreciate that to a certain extent staff were bound by policies and rules, but it is clear from the man's sister that she was never aware of the validated HDC to her home. We therefore make the following recommendation.

    The Governor of Wandsworth and Head of Healthcare should ensure that staff communicate clearly with terminally ill prisoners (and their families) as to which forms of release are appropriate in their circumstances. They should also ensure that staff consider the deteriorating health of the prisoner might change the validity of any particular licence.

Palliative care plans

86. The man's clinical records show that Wandsworth were aware that he was receiving palliative care. After his discharge from hospital in August, a prison nurse contacted the palliative care team at St George's Hospital on 1 September. On 7 September, a palliative care nurse from Trinity Hospice visited the man to discuss his care plans and provide palliative support. He again saw a member of the palliative care team from Trinity Hospice on 29 September.

87. Treatment care plans were in place during the man's admission to Wandsworth's healthcare unit. These were started on 27 August, a day after he was discharged from hospital, and were reviewed on 30 August, 5, 12 and 19 September. They addressed the man's pain management, nutrition, pressure sores and risk of isolation. A further plan was put in place on 23 September, to deal with the possibility of the man having problems with his blood circulation.

88. In his review, the clinical reviewer comments that he was pleased to see the "early and active involvement" of the palliative care team and records a

"commendable level" of detail of sharing of the care of the man, between the prison healthcare staff and Trinity Hospice care team. We concur with the clinical reviewer and note the level of shared care very positively.

Restraints, security and bed watch

89. A concordat is in place between the National Offender Management Service and NHS Counter Fraud and Security Management Service in relation to prisoner escort and bed watch function. It says terminally or seriously ill prisoners may present a lower risk of escape and this should be considered as part of the assessment process. The use of restraints on terminally or seriously ill prisoners should be reviewed regularly taking into account clinical input, and the level of restraints should be adjusted in accordance with any deterioration in the prisoner's clinical condition or the intensity of the treatment that they are receiving. In addition, a fresh risk assessment is required each time a prisoner is moved or their clinical condition is reviewed in order to assess the appropriate level of restraint for transportation to or from hospital and during the prisoner's stay at hospital.

90. Escort risk assessments were completed on both occasions when the man was admitted to hospital on 4 August and 7 October. They concluded that restraints were to be used, but these could be removed for medical treatment with the permission of the duty governor.

91. Restraints were used throughout the man's admission during August because he was mobile and able to move around the hospital independently. However, they were removed on three occasions, following consultation with the duty governor, so that medical procedures could take place.

92. At the time of the man's second hospital admission, he was still mobile and independent although there was some deterioration in his condition, which was evident by his weight loss and diarrhoea. He also ate and showered unaided. The bed watch log shows that between 7 and 11 October, he was treated with antibiotics, painkillers and given a blood transfusion. Restraints were removed on 12 October. This was authorised by a prison manager following a request from a doctor because the man had swollen joints and an infection. He instructed staff to re-apply the restraints if the swelling went down. The restraints were used when the man was taken for an ultrasound scan on 19 October and removed on 20 October. There is no further reference to use of them after this date and his sister confirmed that restraints were removed around two weeks before he died.

93. We are satisfied that the restraints were used appropriately, reviews of their use were conducted at the correct points and that they were removed when the man's risk reduced as his health failed. The bed watch records were completed appropriately and were thorough.

CONCLUSION

94. The man first complained of stomach problems to healthcare staff at Wandsworth on 23 June 2011. Investigations as to the cause were subsequently carried out and he was diagnosed with cancer of the pancreas on 4 August. He was told that his illness was terminal on 19 October.

95. The prison healthcare staff worked closely with St George's hospital staff and palliative care nurses to ensure that the man was aware of his diagnosis. Treatment and care plans were shared appropriately and efficiently and according to the clinical reviewer the man's care was "appropriate and thorough."

96. Unfortunately, when the prison started the process for ERCG, delays were caused by a previous application for HDC. HDC was in fact granted to the man's sister's home on 20 October but this was not communicated to her or the man. The DPSM made a mistake in her initial interview saying that the HDC was not yet validated to the man's sister's address and this caused confusion for the family and the investigation. Nevertheless the man's health deteriorated so quickly that it was unlikely that he would have been discharged from hospital to his sister's address in any event. While the prison was preparing the application for ERCG, the Governor approved ROTL. This enabled the man to die without being subject to a prison escort and was with his family.

97. We are satisfied that the man's clinical care was managed well and that healthcare staff did all they could to assist his diagnosis and subsequent treatment. Prison discipline staff were similarly conscientious in helping him. However, it was unfortunate that a lack of communication with the family regarding the HDC led to difficulties and additional distress for the man in the latter stages of his life and his family.

RECOMMENDATIONS

1. The Governor should ensure that staff who escort prisoners at hospital are familiar with the policies and procedures in respect of visitors, as well as any specific instructions regarding an individual prisoner.

2. Prison staff should give clear written instructions to families, with an appropriate point of contact about arranging visits, security requirements and bringing in property for the prisoner.

3. The Governor of Wandsworth and Head of Healthcare should ensure that staff communicate clearly with terminally ill prisoners (and their families) as to which forms of release are appropriate in their circumstances. They should also ensure that staff consider the deteriorating health of the prisoner might change the validity of any particular licence.