

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Whatton,
in December 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2008

This is an investigation into the circumstances surrounding the death of a prisoner at HMP Whatton. The man died on 26 December 2007 at a hospice local to the prison. He was 49 years old. The cause of death was recorded as acute bronchopneumonia due to metastatic carcinoma of the oesophagus. He was a vulnerable man who was in poor health for much of his time in custody and he received commendable care from all the staff at the prison. Much thought, imagination and attention to detail was given to ensure the man's comfort and safety.

The man had not been in touch with his family for some years and none of his relatives could be traced following his death. Nevertheless, I offer my sincere sympathy and condolences to all those touched by the man's death for their loss. I also apologise to those affected by this report for the delay in producing it.

The investigation was carried out on my behalf by one of my colleagues. Unusually, my investigator had himself met the man and so is able to verify at first hand that he was comfortable, although clearly very ill. An independent review of the man's medical care in prison was carried out on behalf of the Nottinghamshire County Teaching Primary Care Trust. As ever, I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Whatton for their full and ready co-operation during the course of the investigation. I am particularly indebted to the prison liaison officer for the assistance she provided my investigator.

I make two recommendations concerning the arrangements for terminally ill prisoners and highlight one example of good practice.

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SUMMARY

The man was remanded into custody on 11 October 2005. The following year he was convicted and sentenced to five years imprisonment. The man had a number of health problems when he was first received into prison, including chronic obstructive pulmonary disease and asthma. Initially he did not settle well into prison life, and in the first half of 2006 was monitored by the prison's suicide and self-harm procedures.

Following his transfer to HMP Whatton in September 2006, the man settled better into prison life. At the time of his transfer, he began to complain of persistent vomiting and abdominal pain. The man was referred to a local hospital, where he underwent an examination on 29 November. The initial examination was unable to find a cause for the man's symptoms and a further appointment was made, for a gastroscopy (an examination of the stomach using a fibre optic camera), for 14 December.

Before the man could undergo this procedure, he was admitted to the local hospital on 12 December, having experienced severe vomiting and abdominal pain that morning. The gastroscopy went ahead two days later, and the man was diagnosed with cancer of the oesophagus (the tube that connects the mouth to the stomach).

The man remained as a hospital inpatient until 10 April 2007. In that time he began a course of chemotherapy which, due to a gastro-intestinal bleed and a chest infection, he was unable to complete. The man also underwent an oesophagectomy (surgical removal of the part of the oesophagus where the tumour was situated). This procedure was a success and, after a slow recovery, the man was able to return to Whatton.

Around a month after his discharge from hospital, the man began to report pain in his right arm. Following a biopsy in early July, he was diagnosed with skin cancer. He subsequently underwent radiotherapy on 31 July, which reduced his pain over the next few weeks.

Over the next four months, the man lived on the wing at Whatton and was cared for by healthcare staff. His health gradually deteriorated over this time, although he was usually in good spirits and enjoyed a good relationship with staff. On 11 December, the man was released on temporary licence and took a bed in a local hospice. His condition continued to deteriorate and he died at 2.55pm on 26 December.

My report shows that the man received commendable care from the healthcare staff at Whatton. However, I make recommendations in two areas. Firstly, whilst the clinical review concludes that the provision of medication to the man was adequate, there were times when his regime had to be changed due to suspected bullying for his analgesia (pain relief). Secondly, I consider whether the man might have benefited from full-time inpatient care.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 January 2008 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result. My investigator did not interview any members of staff during the course of the investigation. He hoped to interview the former healthcare manager, although was unable to do so as she is no longer employed at the prison. My investigator was, however, able to tour the prison, including the room in which the man lived.
2. My investigator was given access to the man's prison files, including the medical record. An independent clinical review of the man's health needs whilst he was in custody was carried out on behalf of the Nottinghamshire County Teaching Primary Care Trust (PCT).

HMP WHATTON

3. Whatton is a category C prison located around 20 miles from Nottingham. It is a specialist establishment for adult male sex offenders who are required to participate in the Sex Offender Treatment Programme. Additionally, prisoners should not require the services of a full-time medical officer.
4. Healthcare in the prison is commissioned and provided by the Nottinghamshire County Teaching PCT.
5. There are no inpatient healthcare beds and no 24 hour healthcare service in the prison, with no medical staff on site during the evening or overnight. An out of hours service is provided under contract by Nottingham Emergency Medical Services (NEMS).
6. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable to hold it in their own possession. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is considered unsuitable to be held in their possession.
7. Whatton was last inspected by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, in January 2007. Ms Owers found that, whilst the healthcare unit was a clean and clinical environment, "waiting times for the GP were unacceptably long and a major concern". In response to my draft report, the Governor has commented that waiting times to see a prison doctor are now 24-48 hours.
8. The Independent Monitoring Board (IMB) annual report of 2006/07 raised a number of concerns regarding the provision of healthcare at Whatton. Significantly, one of these concerns regarded the availability of palliative and social care for a terminally ill prisoner.
9. This is the 12th death to have occurred at Whatton since April 2004, when I began investigating all deaths in prison custody in England and Wales. It is the tenth due to natural causes. There has subsequently been one further death of a prisoner at Whatton, again from natural causes.
10. Of the previous cases that I have investigated at Whatton, three were of patients suffering from terminal cancer. In one of these cases I recommended that the Governor and PCT should develop a protocol to ensure palliative care for patients is kept under review. This recommendation was accepted in January 2008.

KEY FINDINGS

11. The man was remanded into custody to HMP Nottingham on 11 October 2005. A first reception health screen (a routine health screen for all new arrivals into prison) was carried out following his arrival at the prison. At his reception health screen, the man revealed that he had recently had tuberculosis (TB). He also said that he was asthmatic. As a precaution, he stayed overnight in the healthcare centre's inpatient's unit, until he could see the prison doctor on the following day.
12. The following day, the man's doctor in the community was contacted. He confirmed that the man had been diagnosed with TB in January 2005. The doctor also detailed a history of alcoholism, chronic obstructive pulmonary disease (COPD, the restriction of airflow to the lungs due to the narrowing of airways), asthma, learning difficulties and acute bronchitis.
13. The prison doctor wrote to the consultant ophthalmologist (eye specialist) at a hospital in the man's home area on 28 October, to clarify details of some eye problems that the man had reported. The consultant replied on 2 November, detailing a history of chorioretinitis (inflammation of the retina) from December 2004. He added that the man required follow-up within the next few weeks, and agreed with the prison doctor's suggestion that referral to a hospital local to the prison was appropriate. An appointment was subsequently made at the eye clinic at this hospital on 22 November.
14. The man had taken a cell on the Vulnerable Prisoners' Unit (VPU) at Nottingham, due to the nature of his offence. He was initially noted to be settling well into prison life and was interacting well with his fellow prisoners. However, on a number of occasions in late 2005 he complained of breathlessness and a chest infection. He was prescribed a course of antibiotics by the prison doctor.
15. The good start to the man's prison life did not last, however. On 6 February 2006, an Assessment, Care in Custody and Teamwork (ACCT, the form used by the Prison Service to monitor and support persons deemed to be at risk of suicide or self-harm) form was opened after the man made small lacerations to his left arm with a razor blade. He again made superficial cuts on five further occasions in February and on one occasion in March. The man also received a number of warnings about his abusive behaviour towards staff.
16. The ACCT document was closed on 27 March, but re-opened just five minutes later when the man again made superficial cuts to his arm. He transferred to HMP Woodhill on 7 April, with the ACCT document still open. It was closed sometime during the man's time in Woodhill, although I am unfortunately unable to say when as the necessary documentation is missing.

17. On 12 April, the man was seen by a prison doctor, after complaining of having a cough which produced a green phlegm. He was prescribed a course of amoxicillin (an antibiotic). Around a month later, on 15 May, the man was seen again by the doctor. He continued to complain of a painful phlegmy cough and was diagnosed with bronchitis. The doctor now prescribed a course of doxycyclin (another antibiotic).
18. Following his conviction on 19 May and subsequent sentencing on 29 June, a progressive transfer to HMP Whatton was arranged for the man. Before a prisoner is transferred to Whatton, a nurse at the sending establishment is required to complete a healthcare assessment form. In the man's case, it was completed by a nurse from HMP Woodhill on 9 August. She described his medical history, including COPD, and referred to his history of self-harm.
19. The man subsequently transferred to Whatton on 5 September. His medical history was detailed at a reception screen. An F2052SH (the suicide/self-harm monitoring form that preceded ACCT as Whatton had not yet introduced the ACCT system) was opened as the man said that he was very nervous and concerned about his safety at Whatton. He also said that he was depressed and anxious about his physical health.
20. Two days later, the man saw a prison doctor and complained that he had been vomiting since the previous day. The symptoms continued and over the course of the next week the man also experienced dizziness and abdominal pain. He was not eating well and was put on a course of Fortisips (a nutritional drink).
21. The F2052SH was closed on 21 September, as the man had settled well at Whatton. However, he continued to complain of vomiting and abdominal pain, and was reported to have lost 3kg in weight over the course of the previous week. A request was therefore made to the kitchen for the man to have a soft diet (soup, rice pudding etc) in addition to the Fortisips.
22. An urgent gastroenterology (the branch of medicine concerned with the digestive system) referral was made by a prison doctor on 27 September. The doctor described the man's symptoms as "several weeks of recurrent vomiting after eating" and a "vague sharp central abdominal pain".
23. Having heard nothing following his initial referral, the prison doctor made a second referral on 9 October. He wrote that the man's exact diagnosis was unclear and he had not responded to any interventions that they had made so far. Following the second referral, an appointment was made for the man to see a consultant gastroenterologist at a local hospital on 29 November.
24. An ACCT document (Whatton had by now converted to the new system) was opened on 23 October, as the man had made a minor cut to his left arm. He was low in mood and said that he was distressed because his

stomach problems were preventing him from eating. The document was closed around three weeks later, on 15 November.

25. The man duly attended his appointment at the hospital on 29 November. The Consultant Gastroenterologist was unable to determine a cause of the man's vomiting and weight loss from his initial examination. He therefore requested that a gastroscopy (an examination of the stomach using a fibre optic camera) be arranged. An appointment was subsequently sent through for 14 December.
26. On 12 December, a nurse was called to the man's cell as he had been vomiting profusely and was complaining of abdominal pain. The nurse took clinical observations, including the man's blood pressure which, at 85/65, was low. On account of this, and the severe pain that the man was in, an ambulance was called and he was transferred to the local hospital. He was admitted as an inpatient on arrival.
27. The man remained as a hospital inpatient for four months until 10 April 2007. He underwent the gastroscopy as planned on 14 December 2006, when a tumour of the oesophagus (cancer of the oesophagus, the tube that connects the mouth to the stomach) was diagnosed. The man began a course of chemotherapy on 27 January 2007. Unfortunately, due to a gastro-intestinal bleed and a chest infection, the course had to be abandoned.
28. Because Whatton has no inpatient provision, discussions were held with other prisons in the area with regard to accommodating the man on his discharge from hospital. Both HMP Lincoln and Nottingham were unable to take the man, although healthcare staff at HMP Leicester thought that they might be able to accommodate him.
29. A nurse from Leicester subsequently visited the man in hospital to assess whether they could care for him. Prior to her visit, the man took a turn for the worse. It was now thought that he would die within the next three months. He was receiving medication through a syringe driver (a plastic syringe that delivers small amounts of a drug continuously through a battery operated pump) and was deemed to need full time nursing care. On 15 February, Leicester reported that they would be unable to admit the man as their staff could not manage the syringe driver or the nursing care that he needed.
30. The then healthcare manager at Whatton wrote to the ward manager at another local hospital (to where the man had been transferred) on 20 February, following a meeting on 16 February. The healthcare manager wrote that it was clear that the man would be most appropriately cared for in a nursing home, and that it had been agreed that staff at the hospital would arrange this via the Social Services Department.
31. On 15 March, the man underwent an oesophagectomy (surgical removal of the part of the oesophagus where the tumour is situated). The

operation was a success and the tumour was fully removed, although the man's post-operative recovery was difficult due to another chest infection.

32. The man eventually recovered well from the surgery and improved considerably. It was therefore agreed to discharge him back to Whatton, rather than to a nursing home or hospice. He returned to Whatton on 10 April following a discharge review at which it was agreed that the man did not need any specialist care at the present time. The man settled back well at Whatton. He did not need help with physical activity but staff had to cajole him into eating properly.
33. Following his discharge, the man was prescribed a substantial quantity of medication. This included oromorph (a strong morphine based painkiller) and salbutamol (for COPD) to take as required. He was also prescribed a number of other painkillers, including fluoxetine (an antidepressant), olanzapine (an antipsychotic), diazepam (a sedative), procyclidine (used to control the side effects of antipsychotics), lansoprazole (to reduce acid production in the stomach) and paracetamol (a painkiller). A care plan was produced that determined that the man's medication would be prepared and dispensed by two nurses in healthcare, once in the morning and again in late afternoon. The care plan also indicated that medication should be locked in the man's cell cupboard.
34. Concerns were raised on 19 April that the man's carer (a prisoner who helped him when necessary with cleaning his cell and fetching meals) may have been taking some of his morphine from him. The carer was subsequently replaced. Despite this, the man was in good spirits. On 27 April, the man was taken off oromorph following a review as it was determined that he no longer required it.
35. The man reported pain in his right arm on 22 May. The prison doctor suspected either an abscess (a collection of pus) or metastases (cancer cells that have spread). He referred the man for an x-ray, the results of which, on 31 May, were normal. However, the man continued to complain of pain in his arm and his stomach.
36. At a review with a prison doctor on 15 June, the man said that the pain in his arm had increased further. The doctor therefore increased his morphine. At a nursing review three days later, the lump on the man's arm was noted to be growing and painful to touch. The following week, the man reported that the pain in his arm was worse still. An appointment was therefore arranged at one of the local hospitals for a biopsy on 2 July. The results, which were received on 6 July, confirmed a squamous cell carcinoma (skin cancer).
37. The healthcare manager contacted other healthcare managers at Nottingham, Leicester and Lincoln prisons again on 5 July. She asked if they had any beds available for the man in the event of his deterioration and need for further nursing care. All three prisons said that they were

unable to offer any accommodation. It does not appear that the application to the three prisons was taken any further.

38. Over the following few weeks, the man continued to experience pain in his arm. His morphine was increased on 20 July when he said at a review that he usually woke up in the morning in a lot of pain. At a further review on 30 July a second prison doctor, noted an obvious increase in the size of the man's tumour.
39. The man attended outside hospital the following day for radiotherapy (the use of high energy x-rays to destroy cancer cells in the treated area) to his upper arm. In the days after his radiotherapy, the man reported that the pain in his arm had decreased. At a nurse review on 5 August, the man's arm was noted to be more swollen than previously. There were also blisters forming on his skin due to burns from the radiotherapy. The nurse called the out of hours service for advice, and antibiotics were prescribed.
40. By the middle of August, the man said that he was feeling much better and his pain control was much improved. Nevertheless, the second prison doctor referred him to a local hospice and specialist palliative care cancer unit, on 21 August. In her letter, the second prison doctor requested advice on the man's medication. She also raised the possibility of the man being cared for at the hospital should he deteriorate further.
41. Towards the end of August, the man's pain began to increase again. He was visited by two Macmillan nurses from the hospice on 5 September. The first of the nurses wrote to a prison doctor, the following day, in which she made suggestions for changes to the man's medication. This involved increasing the man's dose of MXL (a morphine based painkiller) so as to provide adequate pain relief.
42. The man was initially happier with his new medication, and reported on 8 September that he was relatively pain free. An entry on 11 September indicated that he attended for his evening medication and was not given opiate analgesia (Sevredol) to take away "as per area manager [who was actually acting healthcare manager, not area manager] who does not support this". At the time, the man was issued with Sevredol on a daily basis, to take as he required. The next entry, on 14 September, notes that the man was issued Sevredol to take as required, together with his other prescribed medication.
43. Over the following days, the man continued to complain of pain. However, he was noted to be using the Sevredol to good effect. It is also clear that he had Sevredol in possession, as was detailed on his prescription chart. The man was seen again by the Macmillan team on 20 September, followed by a multi-disciplinary meeting also attended by the prison doctor and a consultant in palliative medicine at the hospice. The doctor from the hospice wrote to the prison doctor the same day to summarise the main issues. He requested that Whatton arrange a hospital style bed and pressure relieving mattress, so that the man could be as comfortable as

possible. The doctor added that the hospice would be willing to accept the man as an inpatient when he reached the terminal phase of his illness and was bed bound.

44. The doctor from the hospice also emphasised the importance of the man having access to his full PRN (as required) medication to deal with his pain control. It was thought that the man may have been at risk of bullying from other prisoners regarding this medication (particularly Sevredol). The Head of Residence, therefore agreed to explore options for storing the man's medication. At the time, the man collected his Sevredol from healthcare on a daily basis.
45. The hospital bed arrived on 5 October but, due to its size, it had to be put in a cell on A wing rather than B wing, where the man lived at the time. The man said that he was happy to move to A wing, but that he would miss his friends on B wing. The same day that the bed arrived, the hospice doctor visited the man again. He noted that the man seemed much brighter than he had done previously and that his pain was very well controlled at present. He also noted that the man was able to shower and dress himself but that his fellow prisoners were helping him with his personal care. In a follow up letter on 8 October, the hospice doctor confirmed that they would be able to take the man when he was bed bound and in the last few days of his life.
46. At a nurse review on 9 October, the man said that he had been approached by a prisoner on B wing the previous day. The prisoner had asked for some of the man's medication. At a review the following day, the man said that he had been approached twice in the past for his medication. It was agreed that his Sevredol would now be delivered to the man's cell by healthcare staff and locked in a cupboard in his cell. The key to the cupboard would be held by staff in the wing office.
47. At lunchtime on 19 October, healthcare staff were called to A wing to see The man, as he was feeling unwell. The nurse who attended noted that the man was hot and sweaty, his chest was rattling and he looked very unwell. The nurse contacted the on-call doctor, who visited the man later that afternoon. The doctor noted that The man had markedly deteriorated and suspected bronchopneumonia. He arranged for the man to be admitted immediately to a local hospital.
48. The man was discharged from hospital four days later on 23 October, having been treated during his inpatient stay with intravenous antibiotics. He was discharged with a further course of oral antibiotics, with no changes made to any of his other medication.
49. Three days later, the man was reported to have fallen in his cell overnight. He went to healthcare and, whilst no bruises were noted, he appeared pale and unwell. Due to the man's frailty, he was escorted back to the wing in a wheelchair. The following day, a nurse went to the man's cell to issue him with medication. She found the man looking unkempt and

noted that his cell was in a mess. The nurse again issued the man's medication on 29 October. On this occasion she noted in his medical record her concern that wing staff were struggling to cope with his deteriorating condition.

50. The prison doctor reviewed the man on 29 October. She noted that the tumour to the man's right arm had increased in size. On the same day, intelligence was received that the man was selling his Sevredol for cigarettes. The prison doctor made it clear that the man's medication should not be reduced in case he had pain at night. It was decided to try giving the man extra tobacco in the hope that this would discourage him from trading.
51. The man was reviewed again by the prison doctor on 1 November. She noted that his level of mobility had decreased and he was now having difficulty getting out of bed by himself. The hospice was asked whether a bed was available for the man should he deteriorate further. The prison doctor was told that they were currently full, but that a bed might be available in the next week should it be necessary.
52. In early November, the man was weakened by a serious bout of diarrhoea. Despite this he was still able to potter about the wing, although he also began to report difficulty swallowing his medication. As a result, his tablets were changed to capsules, which he found much easier to swallow. The man's hygiene needs were now being met by a healthcare assistant who had been assigned to look after him. The healthcare assistant was funded by the local PCT and would sleep in a room on the wing overnight, attending to the man as necessary.
53. A room at the hospice became available on 9 November. However, as the man was still able to walk around it was decided that he did not warrant the hospice bed yet. The man improved over the next week or so, and he was noted to be more alert, brighter, and more mobile. His medication was changed on 20 November, following concerns that the man had to ring his cell bell at night to get wing staff to open his locker to get the medication. By 28 November, the man's pain control was reported to be much better and he was now using less Sevredol.
54. The pain remained reasonably well controlled in the first week of December. Following discussion with the Macmillan team at the hospice, a full air mattress was provided on 6 December, as the man had been experiencing pressure sores. The man remained in good spirits and was comfortable once his mattress was in place.
55. On 10 December, a side room became available at the hospice. It was arranged for the man to move in the following day. He was therefore released on a temporary licence on compassionate grounds on 11 December. A risk assessment was completed to determine the level of security required. The then Governor in charge of Whatton wrote that "the nature of his offences mean that he must be accompanied by staff". The

man was therefore accompanied by a prison officer throughout his time at the hospice but handcuffs were not used. The officer was instructed to wear civilian clothes.

56. In response to my draft report, the Governor of Whatton wrote that the officer accompanied the man at the hospice “more for support than security”.
57. By 19 December, the man’s condition had deteriorated and a syringe driver was now being used for his pain relief. He died at 2.55pm on 26 December. A post mortem report revealed the cause of death to be acute bronchopneumonia due to metastatic carcinoma of the oesophagus.
58. The man’s next of kin was his brother. He was also believed to have a sister-in-law, the wife of a brother who had died. Sadly neither relative could be traced. The man’s funeral was therefore arranged by prison staff and took place on 10 January 2008.

ISSUES

Quality of care provided at Whatton

59. The clinical reviewer comments on the difficult challenge of managing a patient with a terminal illness in a prison setting. Nevertheless, he describes the medical care that the man received at Whatton as “entirely appropriate”. He describes the healthcare staff’s record keeping as “accurate and contemporaneous” and remarks on how this enabled continuity of care to be achieved.
60. The clinical reviewer goes on to say that he “cannot find any significant shortcomings in how the man was managed whilst at Whatton”. Indeed, he praises the nursing and healthcare staff for accommodating the man as much as they could, and recommends that they are commended for their diligence.

The Governor should commend healthcare staff for the diligent and professional manner in which they cared for the man.

Medication

61. The clinical reviewer comments in his clinical review that “providing in-possession controlled drugs to a patient with terminal care is fraught with problems in the prison setting”. There are a number of examples of staff at Whatton encountering difficulties in providing the man with his medication. This is particularly the case with Sevredol, which is an opiate based painkiller and hence is highly valuable to other prisoners.
62. On several occasions in September and October 2007, concerns were raised that the man may have been being bullied for his medication. Indeed, on 10 October, the man said himself that he had been approached twice for his medication. There was also intelligence that the man might have been trading his medication for cigarettes.
63. Following the allegation of bullying on 10 October, it was agreed that healthcare staff would deliver the man’s Sevredol to his cell, where it would be locked in his cupboard. The key would be kept by wing staff. Prior to this, the man had collected his Sevredol in person from healthcare and had held it in possession (with the exception of one incident on 11 September 2007 when, confusingly, the man was denied his in-possession medication). A more imaginative initiative was to try giving the man extra tobacco to reduce his need to trade his medication.
64. The decision to hold the man’s Sevredol in a locked cupboard in his cell appeared to work well in reducing any alleged bullying. However, there were still some difficulties accessing the medication at night because staff held the key. This led to a change in his medication on 20 November.

65. The clinical reviewer concludes that “nursing and discipline staff both tried to make the best of things but it is the reality of prison life that not all prescribed medication will end up where it is intended”. He goes on to say that, despite these difficulties, “the provision of medication to ease the man’s suffering was adequate”.
66. It is clear that healthcare staff at Whatton encountered difficulties in ensuring that the man was able to access his required medication. However, each problem was dealt with sensibly and quickly. Nevertheless, it would be wise to try to prevent such problems from occurring in the future.

The Healthcare Manager should create an action plan to cover the provision of medication for terminal patients.

Suitability of Whatton to house a terminal patient

67. When the man’s health deteriorated and he entered the terminal phase of his illness he was able to take a bed in a local hospice on 11 December 2007. The clinical reviewer describes the man’s admission to the hospice as “entirely appropriate”. A bed had been available for the man in early November. However, he was still mobile at the time and it had been agreed with the hospice that admission would not be arranged until the man was bed bound.
68. As I have commented earlier, the clinical reviewer says that the medical care that the man received at Whatton as “entirely appropriate”. However, he goes on to consider the lack of inpatient facilities at Whatton. The clinical reviewer comments that:
- “The availability of a bed in a healthcare department to cover overnight and weekend care is essential when diagnosed terminal care patients are under the charge of a prison. The inexorable deterioration in health and inability to self-care is all too predictable...These patients require individual care and security assessments and if their needs cannot be fully accommodated by changes in procedures, without discriminating other prisoners or placing staff at risk, then they should be transferred.”
69. The healthcare managers at Leicester, Lincoln and Nottingham, prisons in the area that do have inpatient facilities, were twice asked by the healthcare manager if they would be able to take the man. On the first occasion, in February 2007, a nurse from Leicester assessed the man in hospital. They later said that they would be unable to take him, as they did not have the facilities to manage the syringe driver that it was thought that the man would need on discharge. On the second occasion, in July 2007, all three prisons decided that they were unable to offer accommodation.
70. Whilst the care that the man received at Whatton was entirely appropriate, it is likely that he would have benefited further from the full time care that

would have been available had he lived on an inpatients wing. I accept that the appointment of a healthcare assistant in the last weeks of the man's time at Whatton was beneficial to him and, effectively, led to there being 24 hour healthcare cover available to the man. However, this does not disguise the fact that staff twice attempted to arrange a transfer to a prison with inpatient facilities, but were unsuccessful.

71. The reluctance of other prisons in the area to take the man is disappointing. There are a number of factors that the receiving establishment must consider in such circumstances, including the availability of a bed in their healthcare centre. However, I would expect a terminally ill prisoner to be a high priority in assigning beds. I do not consider that a terminally ill patient should be in a prison without 24 hour medical care, unless there are exceptional circumstances.
72. Prison Service Order (PSO) 3050 considers the continuity of healthcare for prisoners. It provides details of the information that should be shared between establishments once the transfer of a prisoner with significant health issues is agreed. However, there appears to be no national guidance on how to arrange such a transfer, or the responsibilities of the Service as a whole to those who are terminally ill.

The National Offender Management Service should review its policies and practices in respect of prisoners requiring 24 hour medical care who are currently in establishments with no inpatient facilities.

73. The Governor of Whatton submitted the following in response to my draft report:

“The prison has now extended its healthcare hours to cover the new core day, and believe that it is possible to deliver a standard of nursing care which is equivalent to that offered in the community through responding flexibly to individual patient need, rather than being a necessity to extend its cover to 24 hours. A palliative care lead nurse has been appointed, and Whatton now holds a monthly multi-disciplinary palliative care meeting to review patients with cancer diagnosis, and those on Liverpool Care Pathway. Towards the end of the man's life, his care was being led by a nominated nurse who liaised regularly with the wing staff to ensure that the man was cared for with dignity and respect, giving a more positive end of life experience among people he knew. It is felt that location in a 24 hour prison health centre would not have improved his care or personal experience.”

RECOMMENDATIONS

1. The Healthcare Manager should create an action plan to cover the provision of medication for terminal patients.

Partially accepted – rather than develop an action plan, the prison/PCT have already put in place a new policy for medicines management, a policy for managing controlled drugs and a policy for the delivery of medication by syringe driver.

2. The National Offender Management Service should review its policies and practices in respect of prisoners requiring 24 hour medical care who are currently in establishments with no inpatient facilities.

Local response – at HMP Whatton, the man received the same level of care, if not better, than he would have had in a community setting. “24 hour” inpatient care was not required as extra staff were used to support him during the night, and when he required further specialist care he was transferred to the Hospice. The idea that 24 hour care units are on a parity to the NHS is not the case. The treatment plan devised by the prison’s healthcare and the prison demonstrate that when the man required support from Hospice service he was transferred and that, throughout, he was supported in a sensitive and wholly appropriate way by staff.

National response – transfer of patients to another prison to provide additional care should only occur if it is totally essential. Although there is currently no policy on the transfer of patients, it should occur on a case by case basis taking into account the level of necessity. If NOMS were to review this it should be in consultation with Offender Health.

GOOD PRACTICE

3. The Governor should commend healthcare staff for the diligent and professional manner in which they cared for the man.

Local response – the report commends the care and support provided for the man by the Health Team, but does not mention the managers and prison officers on A8 who were exceptional in their understanding, care and support for the man.