Investigation into the circumstances surrounding the death of a man in April 2011 at HMP Wymott

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Wymott. He was 80 years old when he died in April 2011. A post mortem found that his death was due to an upper respiratory chest infection and liver cancer. He was remanded into HMP Manchester on 14 April 2010. He was later sentenced to nine years imprisonment. After sentencing on 16 July 2010, he was transferred to Wymott where he remained until his death.

I would like to offer my sincere sympathy and condolences to the man's family and all who may have been affected by his death.

The investigation was carried out by my investigator. We would like to thank the Governor of Wymott and his staff for their co-operation during the course of our enquiries.

The local Primary Care Trust (PCT) was commissioned to conduct a clinical review into the standard of healthcare the man received whilst in custody at Wymott. They appointed a clinical reviewer to conduct a clinical review. We appreciate her help and contribution to the investigation.

We make five recommendations as a result of this investigation. These include management of controlled drugs, Do Not Resuscitate (DNR) procedures and the management of compassionate release applications.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2011**

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SUMMARY

1. The man was remanded into HMP Manchester on 20 April 2009, charged with serious offences. He was sentenced to nine years imprisonment and on 16 July 2010, he transferred to HMP Wymott. On arrival he was deemed not fit for accommodation on an ordinary wing and was taken to I wing, a dedicated unit for older and disabled prisoners.

2. On 24 November, he collapsed at the dining table. On examination, he appeared slightly breathless when speaking and would fall asleep without warning, only waking when spoken to. The prison doctor reviewed him the following morning and diagnosed him as suffering from a chest infection. He was prescribed antibiotics and anti inflammatory steroids.

3. He was found slumped in his chair on 4 December. A nurse attended the wing and found him to be mentally alert and orientated. He presented as having some dysphasia (difficulty speaking) and it was noted that he still sounded "chesty". She spoke to the doctor, who advised that he may have suffered from a stroke and should be taken to hospital. He was subsequently taken via emergency ambulance to hospital where he received a chest x-ray. The x-ray showed haziness on the right side of his chest, consistent with asbestosis (inflammatory disease affecting the lungs, caused by exposure and prolonged inhalation of asbestos) and a computerised tomography (CT) scan (three dimensional x-ray) was arranged to investigate this further.

4. On 10 December, he had the scan. This confirmed asbestosis and emphysema (a long-term, progressive disease of the lungs that primarily causes shortness of breath) and also found liver nodules, and a narrowing of the colon. After further investigation at the hospital, he was told that he had cancer, which they believed had spread to the liver, and that the primary location of cancer was probably the upper gastrointestinal tract (which includes the stomach and duodenum – the first section of the small intestine). It was noted that due to his current state of health, he would not be suitable for chemotherapy.

5. He attended a consultation with his oncologist (a physician who specialises in cancer) on 10 March 2011. During the meeting he was told that the tumour was inoperable and medically, in his current situation, was not actively treatable. Hospital staff were unable to locate the exact primary site of the cancer, making it unlikely that they would be able to choose a chemotherapy regime that would be appropriate. It was explained that his life expectancy was months, rather than years and the oncologist spoke in some depth about his prognosis. He agreed with the oncologist that due to his current health, resuscitation would be inappropriate. A "do not resuscitate" plan was implemented.

6. On 14 March, he informed prison staff that he wished to apply for compassionate release. The compassionate release application was started on 22 March. Due to his deteriorating health, on 19 March, after

consultation with the hospice he was placed on a care of the dying pathway. (A care of the dying pathway is a palliative care programme used to ensure that a person is as pain free and comfortable as possible near to the end of their life.)

7. He died in April, in prison with his friend at his bedside.

8. I make five recommendations as a result of this investigation. These include the management of controlled drugs, DNR procedures and the management of compassionate release applications.

THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened by the investigator on 5 May 2011. Notices were issued to staff and prisoners at Wymott informing them of the investigation and inviting them to contact the investigator should they wish to talk to her regarding the investigation. No-one came forward in regard to the notices.

10. The investigator met with the Governor and received copies of all documentation relating to the man's time in custody. The investigator reviewed the documentation enabling her to create a chronological timeline of events of his time at Wymott to identify any early issues.

11. An independent clinical review was undertaken on behalf of the local PCT by the clinical reviewer. I rely heavily on her findings in arriving at my own conclusions.

12. The investigator liaised with the Governor giving feedback throughout the course of the investigation, informing him of her preliminary findings, and highlighting any issues that would be investigated further. Along with the clinical reviewer, my investigator returned to Wymott on 17 June 2011 to interview staff and prisoners as part of the investigation process.

13. HM Coroner for Preston and West Lancashire District was contacted and informed of the nature and scope of the investigation. On completion a copy of the report will be sent to him to assist his enquiries into the man's death.

14. The man nominated his nephew as his next of kin. One of the Ombudsman's family liaison officers contacted his nephew and explained the remit and purpose of the investigation, providing him with the opportunity to raise any questions or concerns he may have about the care his uncle received in prison. His nephew commented that he felt his uncle had been well looked after and had no concerns, at this stage, about the care he received. The only issue he recalled his uncle mentioning was to do with miscommunication between the hospital and Wymott in regards to a blood test, which delayed his treatment for two weeks. He said he did not think it made a difference in terms of his uncle's illness but felt there may be the potential to learn lessons for the benefit of other prisoners.

15. The investigator considered this during the investigation process. There is an entry relating to this matter by the escorting officer in the man's person escort record on 1 February. While at hospital, he was told by the doctor that as some blood tests had not been carried out at Wymott, the procedure scheduled for that day would not go ahead and would be done at a later date. However from reviewing his medical notes, there was no evidence of such a delay being recorded. Healthcare staff stated during interview that they had no recollection of this happening.

16. My investigation assesses the following aspects of his care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether he 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 family was appropriate?
- Whether he 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 WYMOTT

17. HMP Wymott is a category C prison which holds sentenced prisoners. Wymott accommodates both vulnerable prisoners (those who might be vulnerable to intimidation from other prisoners, often due to the nature of their offence) and prisoners on ordinary wings.

18. Mainstream prisoners and vulnerable prisoners are held in separate accommodation and so Wymott is effectively two separate prisons with their own range of workshops, education and training facilities. The prison opened in 1979 and new accommodation was added in 1996. Wymott can hold a maximum number of 1,174 prisoners.

19. Healthcare services at Wymott are commissioned and provided by the local Primary Care Trust. There are no inpatient facilities, and prisoners are transferred to HMP Preston if inpatient care is required.

20. The man lived on I wing, a residential unit dedicated to elderly and disabled prisoners. In addition to the healthcare services provided by the PCT, I wing is also provided with two care workers to help with personal care needs.

HM Inspectorate of Prisons' report

21. Wymott was last inspected by the then HM Chief Inspector of Prisons in October 2008. She commented that:

> "Support for the increasing number of older and disabled prisoners needed development. Healthcare… was in general good, but needed better links with the rest of the prison and better appointments and complaints procedures."

22. The man was located on I wing, a residential unit dedicated to elderly and disabled prisoners. The inspectors found that:

> "A policy for the management of older prisoners had just been developed but had not been fully implemented. An accompanying action plan was based on this Inspectorate's thematic review but did not refer directly to any local issues identified. Over 10% of the population were regarded as older prisoners (over 55) and a separate unit had been established on I wing to cater for some of them, as well as those with disabilities, but the criteria for the wing were unclear … Prisoners on this unit were generally unlocked all day, limited low-level work was available on the unit, and a communal dining and television facility had been provided. Interactions between staff and prisoners on this wing were positive. Regular staff on the wing knew which prisoners in their care needed assistance in the event of an emergency but they did not have personal evacuation plans."

Independent Monitoring Board (IMB) report

23. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. In their annual report for the period June 2009 to May 2010, the IMB made the following comments:

> "Healthcare provision at HMP Wymott is satisfactory but there needs to be an improvement in the level of service in order to bring it up to that provided in the wider community".
>
> "The employment of two care workers from mid-2009 has also been key in improving the daily lives of prisoners on I Wing. Prisoners have described to the Board the many ways in which these carers have helped them to meet and overcome the difficulties of age and disability and the Board is pleased to report this successful aspect of meeting the care needs of such prisoners. The care workers have produced individual care plans for each prisoner but unfortunately, due to staffing difficulties, Healthcare have not yet produced clinical care plans."

Previous deaths in custody at Wymott

24. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 31 deaths at Wymott, of which 26 were due to natural causes. This is in large part to the age of the population at Wymott. There have been four cancer related deaths at Wymott since 2008.

ISSUES

The diagnosis of the man's terminal illness

25. The man suffered from chronic obstructive pulmonary disease (COPD), angina and had a history of heart attacks. He was also a smoker. On 6 July 2009, while in the custody of HMP Manchester, he was taken to hospital complaining of leg pain and a cough. Following a chest x-ray, he was diagnosed with pneumonia and was prescribed antibiotics. A follow up x-ray in September showed that, overall, there was a slight improvement in his condition but he would need a computerised tomography (CT) scan (three dimensional x-ray) to rule out the possibility of bronchial cancer.

26. On 4 February 2010, he had a CT scan of his chest and abdomen. The results of the scan showed that he was suffering from asbestosis (an inflammatory condition of the lungs, due to exposure to asbestos). There were, however, no signs of any malignancy. A week later he had a blood test as he had complained of feeling tired, the results of which showed no abnormalities.

27. On 16 July, he transferred to HMP Wymott. A first reception health screen was conducted and his medical history and general observations, such as his weight and blood pressure, were noted. He was not deemed fit for accommodation on a normal wing and was taken to I wing, a dedicated unit for older and disabled prisoners.

28. A care worker on I wing asked if a nurse could come and assess him on 14 September, as he was feeling generally unwell and was tired all the time. It was noted in his medical record that he appeared gaunt and he had indicated that he had lost weight despite eating well. The nurse took his blood pressure and general observations, but did not check his weight. As he had felt unwell for two weeks and had seemingly lost weight, he was referred to the doctor.

29. He attended an appointment with the doctor two days later. It was noted by the doctor that during the consultation he kept falling asleep while sitting in the chair. No general observations were recorded, such as blood pressure or weight. He was advised to stop smoking as he was suffering from somnolence (drowsiness, a state of near sleep).

30. Another doctor's appointment was made for 20 September. He told the doctor that prior to transfer to Wymott he had been diagnosed with asbestosis. He explained that he was concerned about his health, believing there to be no treatment for his asbestosis, and that he had a poor appetite and found that he was tired all the time. The doctor noted in his medical record that he was suffering from a low mood and a range of blood tests were arranged. The blood test results returned as normal and no further action was required.

31. Further to his comment to the doctor about his tiredness, staff and prisoners on I wing became concerned that he was sleeping a lot during the day. He said he did not feel unwell and was not in any pain, but was just weary and could not keep his eyes open. He was seen by Prison Doctor A on 18 October. Following the examination he was diagnosed with a chest infection and possible dehydration. The doctor prescribed antibiotics and Fortisip (a ready made build-up drink that helps with weight gain). His current weight at this time was 61.1kg.

32. He was reviewed a week later. His chest infection had cleared up and he had gained some weight, now weighing 63.4kg. Encouraged by his improvement, another two weeks worth of Fortisip drinks were prescribed. On 15 November, he was weighed again. It was found that, despite him being prescribed Fortisip drinks, his weight had now dropped back down to 61kg. He was advised to continue having the Fortisip supplement drinks.

33. On 24 November, he collapsed at the dining table whilst having dinner on the wing. He was taken back to his cell, and was examined by Nurse A. He appeared slightly breathless when speaking and would fall asleep when talking to her, although he would awake when spoken to. He told her that he had not been able to eat or drink very much recently and had been coughing up green sputum. After being examined by the nurse he was walked back to the wing by another prisoner, who helped him to bed. Prison Doctor B reviewed him the following morning and diagnosed him as suffering from another chest infection. He was again prescribed antibiotics, this time along with a dose of anti inflammatory steroids.

34. A carer on I wing found him slumped in his chair on 4 December. Nurse B attended the wing and found him in his chair alert and orientated. He presented as having some dysphasia (difficulty speaking) and it was noted that he still sounded “chesty”. The nurse spoke to Prison Doctor B, who advised that as he may have suffered from a stroke he should be taken to hospital. He was subsequently taken via ambulance to hospital for tests. He underwent various blood tests and a chest x-ray. The x-ray showed haziness on the right side of his chest, consistent with asbestosis. A CT scan was arranged to investigate this further.

35. On 10 December, he had the scan. There were no immediate plans to discharge him, so Nurse C visited him on 13 December. On arrival the nurse was advised that he may have had a transient ischemic attack (mini stroke), but they were still waiting for the results of the CT scan. He appeared bright and cheerful and stated he was feeling much better. His speech had returned to normal.

36. The healthcare manager telephoned the hospital on 20 December asking for an update on him. She was told that a colonoscopy was needed. He had the colonoscopy procedure on 23 December and was later discharged from hospital on 29 December.

37. His discharge letter showed that the scan confirmed he had asbestosis, and that nodules had been found on his liver and his colon. The letter also confirmed that the lesions on his colon were benign and he was to be discussed at a multi disciplinary team meeting to discuss his options and further tests. Unfortunately the discharge letter does not contain a prison stamp to show the date it was received, and it is therefore not clear when the letter was received at Wymott. It is also therefore not clear as to when he was informed of the test results and who by.

38. The multi disciplinary team meeting was held on 7 January 2011. It was discussed that he was either suffering from a tumour of the colon which had spread to his liver, or a gall bladder tumour that was invading the colon, resulting in liver metastases (cancerous tumours). A biopsy of his liver was deemed appropriate. A letter summarising the meeting and decisions made was sent to the healthcare centre at Wymott. This letter was received on 17 January.

39. He attended an appointment with a Consultant Colorectal and General Surgeon on 26 January. The consultant explained to him that the colonoscopy had been inconclusive and that he thought his gallbladder was the reason for the tumours highlighted on the scan. He explained that further tests may provide a better diagnosis, and booked an appointment for a liver biopsy.

40. He had the liver biopsy on 8 February, being discharged the next day. The results of the biopsy were to be discussed during a follow up appointment with the consultant.

41. On 18 February, another multi disciplinary meeting was held and his current diagnosis was discussed. A letter was sent to the healthcare department at Wymott, summarising the meeting. It gave details of the liver biopsy, confirming that the cancer had spread to the liver, and that it was probable that the primary location of cancer was in the upper gastrointestinal tract (which includes stomach and duodenum). It was noted that due to his current state of health, he would not be suitable for chemotherapy.

42. He attended a follow up appointment with the consultant on 9 March. He was told during this appointment that the liver biopsies had shown “a poorly differentiated cancer of probable upper GI origin” and that his prognosis was very poor. A referral was made for him to be considered for palliative chemotherapy, but it was explained to him that due to his current health he may not be fit enough to receive it. In a letter summarising the meeting, it was noted that he was likely to get more and more debilitated over time.

43. The oncologist met him the following day. During the meeting he was told that the tumour was inoperable, not curable and, in his current situation, was not medically treatable. He was not fit to have chemotherapy as they did not know the exact primary site of the cancer and so it was unlikely

that they would be able to choose a chemotherapy regime that would be appropriate. It was explained that his life expectancy was months, rather than years and the oncologist spoke in some depth about his prognosis. He agreed with the oncologist that due to his current health, resuscitation would be inappropriate. A "do not resuscitate" plan was implemented.

44. He did not present with specific symptoms relating to cancer of the liver. The diagnosis was made during a CT scan following a stroke while he was also suffering from a chest infection. Following diagnosis of possible liver cancer, a referral was made to an upper gastrointestinal surgeon and the timescale of the referral fell within the two week rule. All relevant information was recorded in his medical record. The clinical reviewer, stated in her report that:

> "The chronology and interviews support [the view that] the diagnosis of his terminal illness [cancer] was made appropriately."

Informing the man about his condition and treatment

45. On 7 January 2011, a multidisciplinary meeting was held between the man's oncologist and his consultant. During this meeting, his test results were discussed and further investigations were advised. He was not present at this meeting, however a letter was sent to Wymott healthcare centre to ensure staff were kept up to date with his appointments and the tests he required.

46. He attended an appointment with the Consultant Colorectal and General Surgeon, on 26 January. It was explained to him that the colonoscopy had been inconclusive and it was believed that his gallbladder was the reason for the tumours showing on the CT scan. The consultant told him that further tests could provide a serious diagnosis.

47. Another multi disciplinary meeting was held on 18 February following his liver biopsy. It was discussed that the biopsy had confirmed that he had secondary cancer of the liver; although the primary site of the cancer was unknown.

48. He attended a follow up appointment with the consultant on 9 March. The consultant told him that the liver biopsy confirmed liver cancer, and that his prognosis was very poor. He advised him that he would be referred for palliative chemotherapy.

49. On 14 March, he attended a multi disciplinary team meeting on I wing. Also present at the meeting was the disability officer, his care worker, the appointed family liaison officer and Nurse C. During the meeting, his diagnosis and prognosis were discussed as well as his palliative care needs.

50. Nurse C emailed a letter to the man's oncologist on 22 March, asking them whether they thought it would be appropriate to put a "do not resuscitate" plan in place, commenting she was unsure how to proceed as the prison did not have their own policy. During a consultation the following day, his oncologist explained that his cancer was inoperable and he was not suitable for chemotherapy. He was told that his life expectancy was months, rather than years. The oncologist spoke in some depth about his prognosis and discussed the issue of a DNR. He agreed with the oncologist that due to his diagnosis and expected deterioration, resuscitation would be inappropriate and the "do not resuscitate" plan was implemented.

51. There seems to have been uncertainty at Wymott about how they could implement a "do not resuscitate" notice. The clinical reviewer, in her clinical review, makes two recommendations on this issue, which I endorse. It is important that these should apply to all staff in the prison who might come into contact with a prisoner in these circumstances, and not only healthcare staff.

    The Governor and Head of Healthcare at HMP Wymott should agree their approach to Do Not Attempt to Resuscitate via a local procedure.

    The Governor and Head of Healthcare should ensure that all appropriate staff should receive training in DNAR procedures.

52. He was offered appropriate support by staff at Wymott, such as holding multi disciplinary meetings during which he was able to specify the care he wanted to receive and ask any questions he may have had. Staff from the local hospice also came to Wymott to provide care and support to him. The clinical reviewer noted that the multi disciplinary meetings and involvement from hospice staff was evidence of good practice. He was adequately informed of his hospital appointments, possible treatments and his prognosis throughout the duration of his illness. The clinical reviewer stated in her clinical review that he:

    > "…received timely appropriate investigations and was fully informed by both hospital and prison staff. He received support from staff within the prison; in addition to this was specialist advice from the hospital, the hospice and Social Services."

The man's medical appointments and treatment

53. He attended all hospital appointments. He was always willing to attend and no appointments were cancelled due to escort or staffing issues.

54. Multi disciplinary meetings were held to discuss his care and on going tests. Although he was not required to attend the initial meetings, this was good practice for managing his care needs with advice and input from various medical practitioners. He attended a multi disciplinary meeting on

his wing on 14 March, during which he was able to have an input and make decisions relating to his care. Appropriate staff were available to explain his options and diagnosis and to address his concerns.

55. On 23 March, he was told that he was not suitable for chemotherapy. The reasons were explained to him and he was advised that he may be able to receive palliative care. Healthcare staff sought advice from the palliative care nurses at the local hospice and he was also visited on the wing by nurses and doctors specialising in palliative care, thus ensuring that his needs were being appropriately met.

56. The clinical review shows that hospital appointments were kept and, following these appointments, treatments, appropriate checks and observations were made. It was noted that the communication between hospital and prison staff appeared to be of a good standard. I concur with these findings.

The man's pain relief and medication

57. Throughout his time in custody, he received appropriate medication to control his symptoms of chronic obstructive pulmonary disease.

58. He started to get stomach pains on 23 February, for which he was provided paracetamol, a mild pain relief, which appeared to control the pain. He also began to feel nauseous when eating and he was told that if this became an issue for him, in regard to comfort and being able to eat, then appropriate medications could be prescribed.

59. On 16 March, constipation medication was stopped due to him experiencing diarrhoea. Medication to relieve nocturnal leg cramps was also stopped, as this was thought to be increasing his feelings of nausea. This appeared to stop the diarrhoea and control the nausea.

60. On 23 March, he was told he was not suitable for chemotherapy and was referred for palliative care. The Oncologist recommended some types of medications that would help ease his symptoms of nausea, loss of appetite and the "band feeling" in his abdomen. These were noted by healthcare staff who could arrange to have them prescribed, if needed.

61. He suffered from oral thrush. On 4 April, he was issued with antifungal medicine to alleviate the symptoms and to treat the infection. He was also provided with glycerine sticks, which help to refresh the mouth when he suffered from dehydration close to his death.

62. Nurse D noted that he looked emaciated and pale on 11 April. She administered liquid paracetamol as he was having difficulty swallowing. By 19 April, it was noted that he was struggling to take even small amounts of fluid and was unable to take his medication. He was subsequently given his medications via injection. These included pain

relief, medication to relieve symptoms of agitation, respiratory tract secretions, nausea and vomiting and a relaxant to aid his breathing.

63. Nurse C said, regarding pain relief, during an interview with the investigator and clinical reviewer,:

> "…he didn't complain of pain for a long time and when he did an occasional paracetamol he maintained would help him and it was only very near his death that he then started to complain that, you know, I've got really terrible pain so I think he only ended up having a couple of doses of the Diamorphine prior to him dying…"

64. On 20 April, his medications were reviewed. All non essential medications were stopped and he was maintained on strong pain relief and medication to help minimise his chest secretions, which were administered by injection.

65. His pain relief was discussed with Nurse C during the interview with my investigator and the clinical reviewer. She detailed an issue of concern surrounding the administration of controlled drugs at night. She explained that there was only one nurse on duty during the night patrol state, and that this presented an issue in regards to administering controlled drugs, such as opiate pain relief. She explained that if a controlled drug had to be administered, two nurses had to be present, one to measure the amount, and the other to check it and then to administer it. He only required administration of a controlled drug (pain relief) on one occasion. However, this resulted in her having to come into the prison at 4.30am when she was not on duty to help administer the drug as he was "really poorly" at this stage.

66. She mentioned that she had raised this issue with senior healthcare staff as she had on previous occasions been asked to assist with another prisoner's medication during the night. However, there had been no progress on finding a solution. She confirmed that she willingly came in to assist, as she did not want the prisoner concerned to have to wait until the morning to receive much needed pain relief. Although it is admirable for her to agree to come in and help during the night, it is not appropriate nor suitable practice for the administration of controlled drugs and a solution to this problem needs to be found. The clinical reviewer makes a recommendation within the clinical review that:

The Head of Healthcare should ensure that controlled drugs for pain relief can be quickly and properly issued at night

67. Overall, his medication was reviewed regularly to ensure his pain needs were met. Appropriate equipment, including a pressure relieving mattress, were provided in a timely manner, minimising any discomfort he may have felt.

Liaison with the man's family

68. He was in regular contact with his nephew and valued the support this provided. On 12 March, he told the Deputy Family Liaison Officer that he wanted his nephew to be kept informed of his condition and care. He was able to talk to his nephew on the telephone and keep him up to date as he wished.

69. He was having problems contacting his nephew to discuss some private affairs due to credit on his pin phone card and the cost of calling a mobile telephone. On 5 April, his personal officer (a named officer to whom he could have gone to for advice or to resolve complaints), facilitated a 30 minute telephone call, allowing him to use a phone in the wing office so he was able to talk with his nephew. Further to this, during a prison visit, the officer sat down with him and his nephew explaining (to the nephew) who he was and discussing his uncle's diagnosis, treatment and care.

70. As his condition deteriorated, he became unable to contact his nephew himself. His nephew was informed of his deterioration in condition on 19 April by a member of wing staff. It was explained that he had deteriorated significantly and staff were monitoring him regularly and meeting his care needs.

71. A governor made contact with the man's nephew following his death. The family liaison officer was asked to contact the nephew by the coroner's officer on 23 April, to explain the procedures following his uncle's death. The family liaison officer telephoned him and confirmed that the family did not want a visit to the prison, that they were happy for the local undertaker to organise the funeral, and that they would like to accept the offer from the prison of assistance with funeral costs. Further procedures were explained, such as the post mortem and the inquest.

72. Contact was maintained with the nephew regarding the funeral arrangements, the post mortem results and any further assistance that the prison could provide. The family liaison officer visited the nephew on 3 May, to return his property and to answer any further questions he had.

73. Good communication was maintained with the nephew throughout the mans illness. A prison family liaison officer (FLO) was appointed and met with him at the multi disciplinary meeting. The FLO liaised with the nephew and discussed aspects of his uncle's care until he passed away. The FLO then had regular contact with the nephew and also visited him at home. He relayed all relevant information and provided appropriate support and reassurance. The nephew spoke very positively about the help and support received from the prison, particularly his family liaison officer who he described as 'brilliant'. He commented that that the prison maintained frequent contact and nothing had been too much trouble.

The man's location

74. The man lived on I wing, a dedicated wing for older and disabled prisoners. Cells are generally unlocked for the majority of the day and there are carers on the wing that help with meeting their basic needs. Carers also keep comprehensive wing notes for each prisoner. The notes relate to their general health and well being and entries are made daily. The notes are a good source of information for other staff should they require it. However, at the opening of the investigation, it was explained to my investigator that they were currently looking to employ a new carer because one of the carers had left. The one remaining carer on I wing explained that due to staff shortages the carers' notes were not being included in the prisoners main healthcare file.

75. She explained that she was overstretched, having to manage the workload intended for two carers, and thus did not have the time to photocopy the notes to then walk them over to healthcare for them to be added to the main files. The carers' notes would have been a valuable tool for healthcare staff when assessing and examining prisoners from the wing. Prior to writing this report, my investigator raised this issue and has been told that a solution has been found. This includes a nurse from healthcare visiting I wing once a week to collect the paperwork, to copy and include in the prisoner's medical records, enabling all staff to have access to relevant information.

76. Following his diagnosis, the man told staff that he wanted to stay on the wing as he had friends and knew the staff. He said he did not want go into a hospital where he would be on his own. When he applied for compassionate release, he said he would like to go to hospice near to his nephew if it was successful, but if not he was content to stay at Wymott.

77. On 23 March, Nurse C referred him to the palliative care nurses at the local hospice. This was to enable him to receive appropriate care while at Wymott ensuring he would not need to be moved to a hospital while his application for compassionate release was ongoing.

78. He was able to remain on I wing throughout the duration of his illness. With regular communication with outside medical professionals, such as palliative care nurses, staff were able to provide him with adequate care on the wing, where he was kept comfortable. On 19 April, all staff on I wing were informed of the deterioration in his condition and were asked to monitor him by healthcare staff.

79. His wishes were respected during his illness, in that he wanted to stay on I wing if he was not able to be released on compassionate grounds. His needs were met appropriately, he was made comfortable and staff had adequate access to equipment to be able to meet his needs. The clinical review states:

> "Due to the dedication of staff, he was able to stay in his cell as his condition worsened and he subsequently dies. The prison sourced equipment needed very quickly to meet his needs… Consideration was given on transfer to a hospital and hospice, but this was not what he wanted."

Compassionate release

80. Following a consultation with him on 9 March, the consultant mentioned in a letter to the prison that would he would become more and more debilitated, and that there were issues that needed to be addressed regarding compassionate release.

81. A multi disciplinary team meeting was held on I wing on 14 March. The man's carer, the appointed deputy family liaison officer (FLO), the disability liaison officer, Nurse C and the man himself attended this meeting. They discussed his diagnosis and prognosis, along with their individual roles. They also spoke about his preferences for his palliative care needs. He said that he wanted to apply for compassionate release, although he expressed a preference to stay at HMP Wymott if the application was unsuccessful, as opposed to going into hospital where he would be alone.

82. A Preferred Priorities of Care document was also completed at the multi disciplinary meeting, where it was documented that he had asked that his nephew be kept informed and updated of his care. He also said that he wanted to see some friends from outside of prison, and reiterated that he wanted to apply for compassionate release. A copy of the document was put in his wing file. Nurse C said during interview with the investigator that the requests outlined by him were facilitated. On 22 March, the disability liaison officer gave her the paperwork relating to applying for compassionate release.

83. On 24 March, Prison Doctor B completed the doctor's section of the release paperwork, some ten days after release was first being mentioned by the man. The doctor wrote that the man had cancer and his prognosis was "poor". He gave the names of his outside consultants and stated that considering the multiple medical problems he was suffering from it was unlikely that he would be able to re-offend in the community. The doctor did not provide any further information relating to his prognosis or life expectancy.

84. PSO 6000 – Parole, Release and Recall, states that "Any other reports which are available, for example from hospital consultants, must also be forwarded. It is essential that an indication of likely life expectancy is included in the report". There were letters from the man's consultants and discharge letters that contained vital information that were easily accessible within his medical record. Prison Doctor B could have used the documentation available to him to support the man's application.

85. Three weeks later the prison probation officer completed the probation section of the application form. She noted that he presented as low risk of re-offending given his age, medical condition and circumstances. She stated that a care home or hospice would be the most suitable type of accommodation as it could be quickly risk assessed should a placement be allocated. She wrote that she supported a release once a suitable placement was found.

86. The three week delay from probation appears to be due to some disagreement in opinion of suitability of release by the man's Offender Manager and the prison probation officer. The Offender Manager wrote a summary of comments relating to the man's request for early release. He stated that he did not support the application for early release for two reasons. Firstly, he did not believe that he had an adequate support system in place from his family and, as he had not engaged in any offending behaviour programmes during his time in custody, he had failed to reduce his level of risk of re-offending, or to raise his victim awareness and empathy levels. As a result of his level of risk, he did not believe that a hospice would be able to provide a sufficient level of monitoring. He had been the man's Offender Manager since December 2010. However, he had never met him, making decisions based on information provided within his pre-sentence and OASys reports written by previous offender managers.

87. Nurse C met with the prison probation officer on 18 April, regarding the man's compassionate release. It was noted in his personal file that the probation officer informed her that no conclusions had been reached and it was to be followed up by the Governor. However, when the investigator spoke with the Governor, he explained that he had not been asked to follow up any enquires in relation to the compassionate release application. He confirmed that he was aware of an issue, explaining that for someone to be released on compassionate grounds they could only be released if they had an appropriate address to go to. The Governor explained that living with family members did not appear to be an option, so alternative accommodation had to be considered, such as the hospice.

88. The final section, to be filled out by the Governor, was not completed. The man died five weeks after the process started, but before the application could be processed. PSO 6000 states that:

> "a decision will usually be made within two weeks, but more quickly if the circumstances require it. If there is a medical application involving a very short life expectancy, the Early Release and Recall section must be alerted by telephone at an early stage."

89. The compassionate release process has been looked at as part of the investigation process and it is apparent that no-one took charge of co-ordinating the man's application. The compassionate release forms were simply passed from one person to the next. This seems to be a

contributing factor in the delays that occurred. Further to this, further information about his illness was available, such as letters from the consultant, and should have been attached to the paperwork.

90. There was a significant delay during the compassionate release process. The process was started some ten days after he stated that he wanted to apply for release on compassionate grounds. The doctor did not provide all the relevant information required and there was a subsequent delay of three weeks for the probation officer to complete their section. There was insufficient sharing of information and regrettably there was no-one co-ordinating the process to ensure its timeliness and the appropriateness of the information being provided. This resulted in the Governor not filling in their section at all and the application not being completed before he died five weeks after the process had started. Due to the above failings I make the following recommendation.

The Governor should ensure that when an application for release on compassionate grounds is received a coordinator is allocated to progress the application in a timely and effective manner.

Palliative care plans

91. A care plan assessment took place on 4 March, by a care worker. In the assessment it was noted that he was “rather frail” and underweight. On some days it was reported that he struggled and could appear unsteady on his feet. He was said to become tired at the efforts to care for himself and sometimes needed assistance.

92. On 18 April, his care plan was reviewed. It was said that he was rather frail and underweight, although he managed quite well considering his current medical condition. At this time he was still able to care for himself, however he was becoming increasingly more dependent. As his condition deteriorated, his care plans were amended and adapted to meet his needs.

93. The care of the dying pathway (Liverpool Care Pathway) was implemented on 19 April, under instruction from the hospice. The pathway paperwork stated that he was bed bound, was only able to take sips of fluid and was no longer able to take medications in tablet form. It was signed by Nurse C and a doctor. It was also noted that he was in poor physical condition and measures were in place to ensure he was comfortable. He received religious support and there appears to have been good communication with his family and the doctor he used to visit whilst living in the community. His medications had been changed from tablet form to injection, and the DNR policy was noted. Discipline staff on the wing were fully aware of the plan for his care, enabling them to ensure his needs were met and relevant information was shared appropriately.

94. The local hospice was appropriately contacted for palliative care advice and input. Care plans were put in place and these were discussed with

him to ensure that his wishes and preferences for care were included, and subsequently the care of the dying pathway was appropriately followed. The clinical reviewer noted the good practice of staff in the clinical review, stating that:

> "His care was well organised, well communicated and he was enabled to choose his pathway for care of the dying."

Restraints, security and bed watch

95. Cells on I wing are open for the majority of the day, most days. This enabled staff to be able to provide him with appropriate care when needed and it was easily accessible to be able to meet his needs.

96. During his hospital appointments, he was escorted by two officers, using restraints. As he was fully mobile and his condition was good during his hospital appointments, the cuffing arrangements were in line with the security policy. At this time, the escorting officers were informed that security measures could be reduced during medical procedures, for example the use of a escorting chain (a long chain with a handcuff at both ends) being used while he was an in inpatient at hospital. Appropriate risk assessments were made prior to hospital appointments and during hospital admissions. The Person Escort Records and bed watch logs entries made were of a good standard and were legible.

CONCLUSION

97. The man was remanded into HMP Manchester on 20 April 2009, charged with serious offences. He was sentenced to nine years imprisonment and, on 16 July 2010, he transferred to HMP Wymott. On arrival he was taken to I wing, a dedicated unit for older and disabled prisoners.

98. He did not present with specific symptoms relating to cancer of the liver. The diagnosis was made during a CT scan following a stroke and chest infection in December 2010.

99. A cancer diagnosis was received on 9 March, when he met with his consultant. He was told during this appointment that tests had revealed that he had "a poorly differentiated cancer of probable upper GI origin" and that his prognosis was very poor. He was informed that that his cancer was inoperable, not curable and medically, in his current situation, was not actively treatable.

100. After he was diagnosed with cancer, the standard of the care he received from staff at Wymott was of a high standard. Advice was sought from the hospice and his nephew was kept informed of all stages of his care. Compassionate release was applied for, but due to delays caused by lack of management during the application process, and quality control issues, he died before the paperwork could be submitted.

101. Towards the end of his life, he had limited ability to participate in agreeing treatment plans, but he had previously voiced his wishes in a general way and what occurred was, in as far as possible, in accordance with those wishes.

RECOMMENDATIONS

1. The Governor and Head of Healthcare at HMP Wymott should agree their approach to Do Not Attempt to Resuscitate via a local procedure.

   National Offender Management Service responded with,

   Accepted – The Lancashire Care policy for Do Not Actively Resuscitate (DNAR) clearly outlines the process. Anybody that has an active DNAR will be regularly reviewed by the consultant and healthcare staff at Wymott. The information will be shared with the residential staff via a memorandum; currently under development is guidance for this process. A target date for completion has been set as December 2011.

2. The Governor and Head of Healthcare should ensure that all appropriate staff should receive training in DNAR procedures.

   National Offender Management Service responded with,

   Accepted - All staff within the healthcare department completes annual basic Life Support Training through Lancashire Care. With additional training in advanced Life Support on offer.

3. The Head of Healthcare should ensure that controlled drugs for pain relief can be quickly and properly issued at night

   National Offender Management Service responded with,

   Accepted - Local training will be provided for Night orderly officers to act as second signatories for the dispensing of controlled drugs on nights. And also following the visit to Whatton we are looking at benchmarking the service for palliative care and the facilities. A target date for completion has been set for December 2011.

4. The Governor should ensure that when an application for release on compassionate grounds is received a coordinator is allocated to progress the application in a timely and effective manner.

   National Offender Management Service responded with,

   Accepted - The Head of OMU is responsible for co-ordinating all licence applications and will ensure that they are completed in a reasonable timeframe. A target date for completion was set for October 2011, and this has now been completed.

GOOD PRACTICE

1. The man was having problems contacting his nephew to discuss some private affairs due to credit on his pin phone card and the cost of calling a mobile telephone. On 5 April, his personal officer facilitated a 30 minute telephone call, allowing him to use a phone in the wing office so he was able to discuss what he needed with his nephew. This was a sensitive solution for him.

   National Offender Management Service responded with, " a letter of recognition and thanks forwarded to the personal officer".

2. Good communication was maintained with the man's nephew throughout his illness. After his death the FLO maintained regular contact with the nephew and also visited him at home. The nephew spoke very positively about the help and support received from the prison, particularly his family liaison officer. He commented that that the prison maintained frequent contact and nothing had been too much trouble.

   National Offender Management Service responded with,"a letter of recognition and thanks forwarded to the deputy FLO".