A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man in June 2012, while a prisoner at HMP Wakefield

Our Vision

*‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’*

This is a report into the death of a man, in June 2012, while in custody at HMP Wakefield. He was 71 years old and died as a result of lung cancer. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to review the man's clinical care. Wakefield prison cooperated fully with this investigation.

The man was diagnosed with lung cancer in November 2011. His treatment options were well explained but he decided against active treatment. The prison put in place appropriate palliative care arrangements and he was fully involved in his end of life care plans. The prison gave good support to his partner after his death, but communication with his family at the end of his life might have been further improved had a family liaison officer been appointed at an earlier stage. Overall, I am satisfied that he was very well looked after and received a standard of care at Wakefield that was at least equivalent to that he could have expected to receive in the community.

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 **December 2012**

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SUMMARY

1. The man was remanded into custody in 1994 and convicted and sentenced to life imprisonment on 23 November 1995. On 29 April 1997, he transferred to HMP Wakefield.

2. The man's health deteriorated in June 2011 and, following assessment by the visiting respiratory consultant, was referred for tests and a biopsy on his lungs. On 11 November 2011, he was diagnosed with lung cancer.

3. In the months that followed, the man was monitored by healthcare staff and the visiting respiratory consultant. Healthcare staff also ensured that he was seen by the Macmillan cancer nursing specialist who provided ongoing support and advice about his treatment and care.

4. He was fully involved in discussions about his end of life care and treatment. He exercised his right not to accept treatment and medication and, for most of his illness, chose to continue to live on a residential wing rather than be admitted to the healthcare unit as an inpatient.

5. On 3 June 2012, his condition deteriorated rapidly and he agreed to be admitted to the prison's healthcare unit, where he died. The prison family liaison officer and the prison chaplain visited his family that same evening to inform them of his death. The prison family liaison officer maintained contact with the family and offered support and help with the funeral expenses.

6. We are satisfied that the care and attention the man received at Wakefield was equivalent to what he could have expected to receive in the community. Support for his family was good but would have benefited from the appointment of a family liaison officer at an earlier stage, about which we make a recommendation.

THE INVESTIGATION PROCESS

7. The investigator visited Wakefield on 7 June 2012 and was given copies of all documentation relating to the man. He met the Acting Deputy Governor and a member of the Independent Monitoring Board (IMB). Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. No one came forward as a result.

8. The local PCT appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of his treatment at Wakefield.

9. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post mortem report. The investigation report will be sent to the Coroner to assist his enquiries.

10. One of our Family Liaison Officers contacted the man's partner to inform her about the investigation and to invite his family to ask any questions or raise any concerns. His family were concerned by his rapid decline in health. They had spoken to him on the morning of his death.

11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP WAKEFIELD

12. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 Category A, B, and high security remand prisoners. There are four main residential wings, a healthcare centre segregation unit and close supervision centre.

HM Inspectorate of Prisons (HMIP)

13. HMIP last published inspection report is of a full announced inspection of the prison in December 2008. A report of a more recent inspection in 2012 has yet to be published. In the 2008 report the Chief Inspector noted that since the last full inspection in 2003:

> "Wakefield has improved considerably over the last five years and it is pleasing that in general the improvement has been sustained. There is still work to be done on aspects of safety, staff-prisoner relationships and activities, but the principal issue to be tackled is how to motivate and engage serious sexual offenders, so that their risk is reduced and they can progress through the prison system."

14. The report noted that some of the health services accommodation was not fit for purpose, but the main health care centre was well resourced. Some prisoners waited too long for routine GP appointments. Emergency resuscitation equipment including automated external defibrillators were located around the prison and regularly checked. A physiotherapist had been appointed and assessed prisoners who used walking aids and saw patients on referral. There was an older prisoners' policy and work to meet their specific needs was being developed, but many older prisoners told inspectors they did not get enough support. Some cells had been adapted for prisoners with mobility difficulties.

Independent Monitoring Board (IMB)

15. Each prison has an IMB made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In its latest published report for the year to April 2011 the IMB commented:

> "The Primary Care Centre pharmacy and GP service is operated by a healthcare provider, and during the report year a number of additional facilities have been provided that have built on the comprehensive service outlined in last years report. There are a number of regular clinics in operation dealing with chronic conditions such as diabetes, coronary heart disease and respiratory disorders. These, together with the Primary Care Centre treatment room introduced last year, have uncovered more illness among the offender population. The number of GP hours available has been increased to meet this demand.

> “Overall, the Health Care Unit provides a comprehensive service that meets the needs of the prison population to a level equivalent to that available to the general public via the NHS.”

16. The IMB noted that the number of elderly offenders at the prison continued to increase and that there were specific learning and skills sessions to meet their needs.

17. The man’s death was the fifth from natural causes at Wakefield in 2012. There were no significant similarities between any previous deaths except that the age of most reflected the older population at Wakefield.

ISSUES

The diagnosis of the man's terminal illness

18. The man had smoked for many years and also previously worked with asbestos. In February 2011, he complained of being short of breath. He was originally treated with antibiotics for a chest infection, but as the symptoms persisted prison doctors referred him for chest X-rays which were taken on 7 June 2011. The X-ray results indicated a problem with the right lung. A visiting respiratory consultant saw him on 10 June, and arranged for a CT scan. The results of the CT scan were reviewed by the consultant on 8 July, who suspected that he had cancer. A palliative care plan was put in place on 17 August. Following further tests, and a biopsy operation at hospital, the consultant confirmed the specific diagnosis that the man had Epithelioid Mesothelioma (lung cancer).

19. The clinical reviewer states in his report:

> "The man was provisionally advised a week after the procedure that it looked like he had a tumour/cancer but were waiting on further tests results. He was made fully aware of the possibilities of his condition pending further results. He expected the worst and was in discussions with his wife and close family for support. In November he was finally diagnosed with lung cancer and was immediately referred to Oncology specialists for due consideration for radiotherapy / chemotherapy treatment.
>
> "The Consultant Respiratory Physician at hospital discussed the newly found diagnosis of lung cancer in addition to the treatment options and prognosis of the condition with him who, after an initial short spell of radiotherapy treatment, declined any further investigations and treatment other than oral medication."

20. We are satisfied that the diagnosis of the man's terminal illness was timely and appropriate.

Communication with the man about his condition and treatment

21. The respiratory consultant and healthcare staff ensured that the man was fully informed at all times about his condition, from the initial diagnosis and throughout his ongoing treatment and care. He saw the consultant regularly to review and monitor his condition and make any necessary changes to his prescribed medication.

22. A nurse saw the man regularly to review his palliative care plan. On 29 January, she advised him that he should be admitted to the prison healthcare unit as an inpatient so that healthcare staff could manage his condition and meet any changes in care he required. He declined as he wished to remain on the wing with his friends and be as independent as possible.

23. The man had three sessions of radiotherapy treatment but chose not to continue with the treatment because of the side effects. He was offered chemotherapy treatment but chose not to have it. He also declined to take the pain relief medication advised by the Macmillan cancer nursing specialist.

24. By 4 May 2012, the man's condition had deteriorated and contrary to medical advice, he decided not to take any of his medication. The consultant saw him on 11 May, and advised him that it was in his best interest to be admitted to the healthcare unit. He continued to prefer to live on his wing, but he agreed to take prescribed pain relief.

25. The consultant next saw the man next on the 25 May, when he recorded that there had been a significant deterioration in his condition. The doctor's prognosis was that he had less than three months to live.

26. In his report the clinical reviewer comments:

> "There is clear evidence from the clinical notes that the man was given full information at each stage of his illness for the reasons for investigations and consultant referrals.
>
> "When the terminal diagnosis was reached he was told in a timely and sympathetic manner.
>
> "Psychological support was provided by the primary care team and visiting clinical consultants."

27. The sensitive and professional approach of the staff at Wakefield ensured that the man was kept informed about his condition and was treated with dignity at all times and his wishes regarding his treatment were respected.

The man's medical appointments and treatment

28. Following his diagnosis of cancer, the man was under the care of the respiratory consultant. Prison healthcare staff liaised with the Macmillan palliative nursing care specialist to ensure he received all the appropriate treatment, although he often exercised his right not to receive treatment or medication. He attended hospital for radiology treatment on three occasions but chose not to continue with that treatment.

29. The opinion of the clinical reviewer is:

> "There is clear evidence from the well documented clinical notes that the man received an excellent standard of care and equal measures of on-going psychological support from the primary care team, Macmillan Nursing support team and visiting clinical specialists.
>
> "Overall he received an excellent standard of care at HMP Wakefield. His care was more than equitable to that which he could have expected in the community".

30. We agree with the clinical reviewer's comments and consider that the treatment the man received was equivalent to what he could have expected in the community.

Restraints, security and bed watch

31. As the man declined active treatment and intervention for his illness, he had no recent appointments outside the prison before his death. His last outside hospital appointment was on 8 March 2012, three months before he died.

The man's pain relief and medication

32. The man was prescribed medication as directed by the respiratory consultant and a Macmillan nursing specialist. In relation to his pain relief and medication, the clinical reviewer said:

> "He was prescribed oral analgesia and anti-Inflammatory medication for a number of months as this was clearly controlling his pain and was clearly evidenced in the clinical notes. Increased pain relief was offered to him but he refused to accept the medication. Although he was reviewed on a regular basis by the Primary Care Team, Macmillan Team and visiting clinical specialists his condition and pain remained fairly stable for a few months despite his prognosis.
>
> "In the remaining few months of his life his condition began to deteriorate and a detailed Gold Standard Framework-Care plan was up dated which now included a new range of medication to control the pain (Morphine Sulphate) and (Oramorphine) in addition to other medications prescribed to improve his pain, well-being and daily life. He refused this help and in addition also refused an Air Flow mattress and admission to the prison Health Care Centre.
>
> "There are many entries within his clinical notes of nursing staff spending time clearly detailing and explaining the benefits of the prescribed medication to improve his pain. He continued to refuse all help apart from simplistic oral pain relief until a week before he died."

33. In light of the clinical reviewer's comments, we are satisfied that the man was offered appropriate medication and pain relief.

Palliative care plans

34. The man was fully consulted on palliative care and end of life plans to ensure his wishes were complied with.

35. In his report the clinical reviewer assesses that:

> "An end of life care pathway was commenced based on the Gold Standard Framework (GSF). GSF aims to provide self-determination and involves

empowerment and enablement of people nearing the end of life, to help them understand choices and exercise some control over events. This means constantly listening to the patient, helping them think ahead with the use of an Advance Care Planning discussions, organising and pre-planning care in response to these needs, and at all times treating them with due respect and dignity as they move along this important final journey with particular attention to control of symptoms, continuity of care, carer support and intensive support and input in the later stages of life. In his case his care plans were well documented, very detailed and paid attention to both his physical and emotional needs."

36. We agree with the comments made by the clinical reviewer and consider that Wakefield's sensitive handling of the man's end of life care was commendable.

Liaison with the man's family

37. The man's partner visited him regularly throughout his time in custody and he telephoned her every day. He had kept his family informed about his diagnosis and the consultant offered to meet them if they wished. The last telephone call between him and his family was at 10.08am on the day of his death.

38. On the evening of his death, the prison family liaison officer and prison chaplain visited his family to break the news, offer condolences and support. This came as a great shock to his family having spoken to him that morning. His final decline in health was very rapid. In the days that followed the prison family liaison officer maintained contact with his family to provide continuing support and, in line with Prison Service policy, offered financial assistance towards funeral expenses.

39. Although the man was in regular contact with his family we consider that Wakefield should have appointed a family liaison officer sooner. This would have provided a single point of contact for his family and allowed some discussion and agreement about when and how his family should be contacted. It is possible that a family liaison officer would have contacted his family at some stage on 4 June, but we recognise that his death came very suddenly and was a shock to his family as they had spoken to him only that morning. Prison Service guidance (PSI 64/2011) recommends that "arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill". The PSI comments that "With the prisoner's agreement, the family should be kept informed and updated on the prisoner's condition particularly if there is deterioration in their condition". We therefore make the following recommendation:

    The Governor at Wakefield should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness and ensure that families are kept informed whenever there is a significant change in the prisoner's condition.

The man's living arrangements

40. The man wanted to remain on his wing with his friends for as long as possible. Healthcare staff had advised him from 29 January that he would benefit from being admitted to healthcare but he declined the offer. While he remained on the wing healthcare staff maintained regular contact with him to monitor his condition and health needs. He had a cell on the ground floor, near to the wing office. A prisoner carer was appointed to assist him in cleaning his cell and collect his meals when he felt unwell. He was offered a pressure relieving mattress and pillows, first on 30 December 2011, and several times in the months that followed. Each time he declined.

41. He finally agreed to be admitted to healthcare as an inpatient on 3 June, the shortly before his death.

42. The clinical reviewer states that:

> "He eventually accepted the offer of help and agreed to be admitted to the inpatients unit for his remaining 24-36 hours. He received close staff support and during his remaining few hours of life was nursed in the unlocked palliative care suite within the Health Care Centre."

43. We are satisfied that Wakefield responded appropriately and sympathetically to the man's wish to continue to live on his wing as long as possible where he had the support and company of friends.

Compassionate release

44. Prisoners can be granted early release on compassionate grounds on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is only granted in exceptional circumstances. Early release on compassionate grounds can be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. The decision to grant early release on compassionate grounds is made by the Secretary of State, taking into account information provided by the prison and medical opinion

45. An application for the man's compassionate release was made on 10 February 2012, but was rejected on 20 April 2012, as it was not clear at that stage that he only had a short time left to live.

46. When the man's condition deteriorated on 25 May, the respiratory consultant made the prognosis that he had less than three months to live. This was just nine days before he died and a suitable hospice place would have needed to be found. One of Wakefield's managers discussed the possibility of compassionate release with him. He said he now wanted to stay with his friends on the wing and, after the previous rejection of his application, he did not want to apply again. The manager agreed to prepare papers for an application in case he changed his mind.

47. We are satisfied that Wakefield acted appropriately in relation to the consideration of compassionate release and ultimately respected the man’s wishes.

CONCLUSION

48. During his time at Wakefield, the man had well documented regular interventions with doctors and other healthcare staff. Although he mostly declined active treatment there was very good liaison between prison healthcare staff and a Macmillan cancer nursing specialist to ensure he was offered appropriate treatment and medication.

49. He was actively involved in the discussions regarding his end of life care and staff at Wakefield abided by his wishes.

50. His family were in regular contact with him, but a family liaison officer had not been appointed when he was diagnosed as terminally ill as recommended in Prison Service guidance.

    The man's family received a copy of the draft report as part of the consultation period. The family said they agree with the recommendation made in this report as they said they would have benefited with earlier liaison and updates with the prison regarding his illness.

RECOMMENDATIONS

1. The Governor at Wakefield should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness and ensure that families are kept informed whenever there is a significant change in the prisoner’s condition

   The Prison Service has rejected this recommendation, and made the following comments:

   “Wakefield would appoint a family liaison officer when appropriate to a prisoner's individual circumstances. In the case of a terminally ill prisoner, this would normally occur when an individual’s condition deteriorated to a degree that death was likely in the near future and/or they became severely incapacitated. Specific consideration is given to the prisoner's ability to maintain ongoing contact with their family/friends and their wishes.”

   “The man remained on the wings up until his death and, whilst seriously ill, he was engaging to some marked degree with the normal wing regime. It is evident from his refusal to transfer to healthcare prior to the 03/07/12 that it was his wish to remain independent and in control of his own personal affairs. Immediately prior to his death, the most accurate prognosis which prison staff were aware of was that he had in excess of 3 months to live.”

   “Furthermore, his S1 record and Nomis Case Notes indicate that he was content in maintaining dialogue with his family and the prison felt that Data Protection Act requirements would prevent them from engaging with his family without his consent. He was also in direct contact with his family up until the date of his death as confirmed by a review of his phone records.”

   “The prison did not know that he was so ill that he would die when he did and the key role of a family liaison officer is to inform and support the family. In this case, knowing the prisoner as they did, the prison decided that his own contact with his family was the most appropriate. Had they known that he would die so suddenly they would have acted differently.”

   “The man’s health deteriorated very suddenly and on reflection, the prison believes it may have been appropriate to appoint a family liaison officer from his reception to the healthcare centre on the evening before he died.”