Investigation into the circumstances surrounding the death of a man at HMP & YOI Altcourse in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2011

This is a report into the death of a man, who died at HMP Altcourse in May 2010. He was 73 years old, and died of natural causes. He had been diagnosed with a lung tumour several weeks earlier.

I would like to extend my condolences to his family and friends, and all those touched by his death. I am sorry that my report has been delayed and regret any additional distress this may have caused. The investigation was conducted by one of my senior investigators. One of my Family Liaison Officers spoke to the man's brother about the care he received at Altcourse, and I am grateful for his contribution to this report.

I would like to extend my thanks to the Director of Altcourse and in particular to the liaison officers for the investigation. A clinical review was commissioned through the local Primary Care Trust (PCT) and they appointed a clinical reviewer to undertake the review. I am grateful to him for his thorough and timely contribution to this report.

He was already ill when he arrived at Altcourse in 2007. He had several ailments, including a chronic leg ulcer, chronic obstructive pulmonary disease, asthma and coronary heart disease. He attended hospital regularly and was, for most of his time in prison, an in-patient in healthcare. In March 2010, doctors suspected that he might have lung cancer and, when this was diagnosed, he was given a prognosis that he had only a few months to live. His condition deteriorated quickly and he died in the healthcare unit which is where he chose to remain.

The review has identified that the care and treatment offered to him at HMP Altcourse was of an adequate standard.

I make no recommendations as a result of this investigation. I do, however, note two areas of good practice. They relate to the referral of him, a new and elderly prisoner, to the mental health nurse and counsellor; and family liaison.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **February 2011**

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SUMMARY

The man was sentenced to eight years imprisonment at Crown Court in August 2007. This was his first experience of prison. Before coming into prison, he had been diagnosed and treated for a number of illnesses including chronic obstructive pulmonary disease, (a serious illness of the lungs), heart problems and vascular (narrowing of the arteries) disease.

He began his sentence at HMP Altcourse and, from late 2009, spent most of his time in the healthcare centre. In May 2010, he was diagnosed with advanced lung cancer and he was referred to a consultant in palliative care (care that is aimed at reducing pain and discomfort at the end of someone's life).

When it was realised that his health was deteriorating, staff at Altcourse contacted his brother and arranged for him to visit the prison. The visit took place in healthcare and prison staff took his brother back home afterwards.

He passed away on 23 May, during the night, in his cell. The clinical reviewer has concluded that the care provided to him was equivalent to that he would have received in the community.

I make no recommendations. I do, however, note two areas of good practice. They relate to the referral of new and elderly prisoners, such as him, to the mental health nurse and counsellor; and family liaison.

THE INVESTIGATION PROCESS

1. This office was notified of the man's death on 24 May 2010. An investigator was appointed to lead the investigation on my behalf. On his initial visit to the HMP Altcourse, he met the Director of Altcourse and an officer. He also visited healthcare to see the man's cell, and met with a member from the Independent Monitoring Board.

2. Notices of the investigation were issued to both prisoners and staff asking anyone with information that they wished to share to come forward. However, no responses to these requests were received.

3. The investigator wrote to the local PCT to request a clinical review of the care the man received at HMP Altcourse. A clinical reviewer was commissioned to conduct the review and he received all the relevant medical documentation in order to complete his report.

4. One of my family liaison officers contacted the man's brother, his nominated next of kin. He provided a useful insight into the care his brother received while at Altcourse, and how he himself was treated. I am grateful for his contribution.

5. Following the publication of the draft report, the family liaison officer contacted the man's brother, who confirmed that he had read the report and had no further comments to make. He did, however, say that the fact that his brother had not wanted to move to a hospice spoke volumes about the care he had received at Altcourse. NOMS also responded to the report. They were pleased that the good practice had been recognised.

HMP ALTCOURSE

6. Altcourse is a category B local prison near Liverpool. It is contracted by the National Offender Management Service (NOMS) and run by G4S, a private company. It serves the courts from Merseyside, Cheshire and North Wales, and holds sentenced and unsentenced adults and young offenders. There are seven residential units and a separate healthcare unit.

7. Healthcare services at Altcourse are commissioned by Liverpool PCT and have been delivered by G4S since August 2009. (Before this, healthcare was contracted to a different company, Medacs.) An outpatients clinic is available every weekday, and the inpatients unit, which can hold up to 13 patients, is staffed 24-hour by nurses. Additionally, doctors are on call 24 hours a day for more serious incidents.

HM Chief Inspector of Prisons report

8. The last inspection report covers a full, unannounced inspection in January 2010. In the section on healthcare in the report, inspectors noted that:

> "Health services were provided by an in-house team, most employed by G4S. A health needs assessment had been completed and was regularly updated. A range of health services was available. There had been a lack of senior management due to the long-term absence of the healthcare manager. Primary care was basic, with little chronic disease management. GP provision was comprehensive, but waiting times were too long. Dental services were very good and a full range of treatment was offered. Pharmacy services were satisfactory, but some attention to medicine management and administration was needed. Mental health services were good, with some very good joint working between primary and secondary services. Inpatient services were only basic. There was no day centre."

Independent Monitoring Board report

9. The Prisons Act 1952 requires every prison to be monitored by an Independent Monitoring Board (IMB) appointed by the Secretary of State from members of the community in which the prison is situated. The Board is specifically expected to:

    a. "Satisfy itself that those held in custody within its prisons are treated humanely and fairly and that there is a range of appropriate programmes to prepare them for release.
    b. Inform the Secretary of State promptly of any concerns.
    c. Report annually to the Secretary of State on how well the prison has met the standards and requirements set and what impact these have on those in its custody."

    To enable the Board to carry out those duties effectively, its members have right of access to every prisoner and every part of the prison and also to the prison's records.

10. The latest published report for Altcourse IMB covers the period from July 2009 – June 2010. In the section on Healthcare, there are no issues raised that are relevant to this investigation.

Previous deaths in custody

11. There have been 17 deaths in custody at Altcourse since my office took responsibility for investigating such deaths in 2004. Eight of the deaths were due to natural causes. Since the man's death, there have been two further deaths in custody. Of the deaths that have occurred since 2008, and for which investigation reports have been published, there are no issues that are directly relevant to this investigation, although in one case the circumstances of the death were similar.

KEY EVENTS

12. The man was born in Wales in 1936. He was convicted of various sexual offences on 24 August 2007 at Crown Court and sentenced to eight years imprisonment.

13. The same day, he began his sentence at HMP Altcourse. A health screen interview was conducted by a health care worker (HCW) after he arrived. He confirmed that he had several problems with his health, including asthma, angina, coronary heart disease, a leg ulcer and chronic obstructive pulmonary disease (COPD). He had been prescribed various medications for these ailments, including inhalers for his asthma. He confirmed that he did not have any mental health issues, and did not use alcohol or illegal drugs, although he was a heavy smoker.

14. He was seen by Prison Doctor A the following day. The doctor noted that he had several medical conditions and listed him for reviews for both heart disease and COPD. He was also seen by a mental health nurse, a routine arrangement as it was his first time in prison. The nurse noted that he showed no signs that he might harm himself, but did refer him for counselling to help him come to terms with his circumstances. He was seen by a counsellor regularly for the next two months.

15. On 14 September, he saw the prison doctor again, complaining of breathlessness. He said that he did not think that his inhalers were effective. The doctor prescribed a different inhaler, Serevent, which he later said he thought was beneficial. Over the next few months, he attended healthcare frequently, usually to have the dressing changed on his leg ulcer.

16. He saw a mental health worker on 24 January 2008. He said that he still had physical problems, but appreciated the help prison and healthcare staff were giving him. He said that his medication was brought to him every day, and he was accommodated on the ground floor (and in a bottom bunk) because of his health. Although his cellmate had his own problems and harmed himself, he felt able to talk to him and thought that he was a positive influence on him.

17. Later the same day, he was admitted to healthcare after officers became concerned about his breathing difficulties. After treatment overnight with a nebuliser (a machine which administers medicine in the form of a mist), he returned to his wing.

18. He continued to see healthcare staff regularly. On 4 March, he was admitted to healthcare by Prison Doctor B as he had worsening leg oedema (a swelling of the leg caused by fluid retention, which can be a sign of increased heart failure). On 7 March, however, his blood pressure was found to be low and he was taken to hospital. He remained there until 17 March.

19. On his return to Altcourse, he was readmitted to healthcare. He had been prescribed different medication and inhalers, and had stopped smoking while in hospital, although he said that he still felt unwell. He remained in healthcare until

25 April, when Prison Doctor A thought that he was fit enough to return to the main prison.

20. He was seen again by the doctor on 3 May, after complaining of increased breathlessness and swelling in his ankle. The doctor decided to change his medication. He continued to go to healthcare regularly because of his ulcer and, on 27 October, the doctor decided to refer him to a vascular consultant (vascular consultants specialise in diseases of the blood vessels). On 5 November, he was readmitted to healthcare to enable staff to monitor and treat his leg ulcer.

21. He went to an appointment with a consultant vascular surgeon at hospital on 11 December. The consultant reviewed the ulcer and suggested that a vascular graft might be appropriate once the ulcer healed. Another appointment was made for a further three months time. He returned to Altcourse that day.

22. Over the next two months, he remained in healthcare. He was described as mixing well with other prisoners, and remained mobile, often using a wheelchair. On several occasions, however, he complained of vomiting. On 16 February, Prison Doctor A referred him to a specialist at hospital for further investigation.

23. On 9 March, he saw a consultant physician at the hospital. The consultant referred him to an "oxygen clinic", and noted that he had both moderate COPD and extensive emphysema (a long term, progressive disease that causes shortness of breath).

24. He was seen by a specialist surgical registrar on 30 March, for investigation into his complaints of nausea and vomiting. The registrar found that his liver was enlarged and his abdomen slightly distended. He also found that his epigastrium (the upper area of the abdomen) was tender. He arranged for a gastroscopy (a procedure in which a camera is used to view the alimentary canal) and an ultrasound scan to be conducted.

25. On his return to Altcourse, he complained that he was breathless and had some chest pain. Prison Doctor A prescribed a course of antibiotics. He was seen in the oxygen clinic at hospital on 29 April, and advised that he should use his oxygen concentrator (a machine which provides oxygen therapy for patients at higher concentrations of oxygen than found in the atmosphere and an alternative to oxygen tanks). Over the next few weeks, he was treated for a lesion on his forehead until, on 2 May, Prison Doctor C made a fast track referral for him to see a consultant.

26. He saw a dermatologist at hospital on 18 May. He was referred to the Plastic Surgery and Burn Unit at another hospital. The lesion was removed on 26 June. A follow-up appointment on 3 August was missed because there were no escorts available.

27. In September, he again complained of nausea and vomiting. After a test, he was diagnosed as having heliobacter pylori, a bacterium that can lead to inflammation of the stomach. Prison Doctor A prescribed a course of antibiotics. On 18 September, he told staff that he had fallen in his cell at 5.00am, although he had

not hurt himself. The following night, staff made regular checks and he appeared to sleep well.

28. Later that month, on 21 September, he saw a consultant surgeon at hospital. In a letter to healthcare, the consultant explained that he had conducted an ultrasound on him, which had revealed nothing, although an endoscopy (a procedure using a camera to view the alimentary canal) showed that he had reflux disease (in which stomach acid returns to the oesophagus). The consultant thought that no further treatment was required as he was already taking the correct medication.

29. Prison Doctor A prescribed a further course of antibiotics on 5 October, as he again had a chest infection. On 21 October, he said that he had a "missed heart beat". Prison Doctor C asked for an ECG (electrocardiogram, a test which measure electrical activity in the heart) to be conducted. The ECG was normal. Prison Doctor A did, however, discuss him with a consultant cardiologist.

30. He moved from healthcare to the main prison on 25 November, as another patient was suspected of having swine flu. He was certified as being well enough for the move to take place. He returned to healthcare on 3 December, and started another course of antibiotics for a chest infection on 7 December. Prison Doctor C saw him again on 8 December, and sent him to hospital as he had low blood pressure. He returned from hospital with advice to continue with the course of antibiotics, but consider reducing the amount of warfarin (which thins the blood) and antihypertensives (which lower blood pressure).

31. On 3 January 2010, he was seen by Prison Doctor A, who asked for urgent blood tests to be done. One of these was to test for INR (the internationalised normalized ratio, a measure of how well the blood clots). His result was nine, which is very high, and the doctor immediately sent him to hospital. He remained in hospital overnight for further tests, and returned the next day with the advice that the warfarin should be stopped.

32. Prison Doctor C noted on 7 January that the scar from the earlier plastic surgery was not healing well. He referred him back to the surgeon. He continued to experience problems with vomiting and nausea, and it was noted that he had lost seven kilograms of weight in the previous ten months. Prison Doctor A referred him to a consultant gastroenterologist (a doctor specialising in illnesses of the alimentary canal) again on 18 January. He also asked for an opinion about his diet from the Speech and Language Therapy (SALT) team at the hospital. (Liverpool PCT later advised that he did not meet their criteria for referral to the SALT, which, as well as speech and language issues, also deals with problems swallowing.) A liquidised diet was ordered for him in the meantime.

33. He saw Prison Doctor C again on 24 January, after staff had noticed him secreting some medication. Although he denied this, he said that he had financial problems outside prison and felt low sometimes. The doctor made an appointment for a mental health nurse to see him.

34. The next day, Nurse A went to see him in his cell in healthcare. He told her that he felt low, because of his illness and the lack of contact with his family. He said that he did not want to burden them with his troubles, and became quite emotional. She advised him to write to his brother and sister and let them make their own decision whether or not to come to see him. She discussed the conversation with Prison Doctor A, who agreed to review his medication.

35. Another mental health nurse (who first met him after his reception), saw him again two days later. On this occasion, he said that he had "up and down days", but that he did not need any anti-depressants.

36. Over the next week, he remained unwell, having difficulty eating. He was well enough, however, to attend an appointment with the plastic surgeon on 8 February, who gave advice on managing the scar on his forehead.

37. On 8 March, he attended hospital again to have the scar examined. On his return, it was noted that his arms were bruised, and the skin on his left arm was broken. The Nurse Manager wrote in his medical record that the bruising was "from what appears to be the cuffs". (Restraints were assessed as necessary and so, on subsequent hospital visits, bandages were applied beneath the restraints to prevent further skin damage.)

38. During the next month, healthcare staff continued to try and help him to eat. They worked with him and the prison kitchen to arrange smaller and softer meals in addition to the plan of liquidised meals.

39. He next attended hospital on 19 March for further investigation into his problems with swallowing. He was examined by a hospital doctor, who believed he might be suffering from a neoplasm (an abnormal proliferation of cells) in his oesophagus, with a possible lesion on his lung. The doctor arranged an urgent OGD (oesophagogastroduodenoscopy, a procedure where a camera is used to view the upper gastroenterinal tract) and chest x-ray.

40. The next hospital appointment for he was on 31 March, when he went to the CT (computed tomography, a method of imaging the body) department at hospital for a scan on his chest and liver. On 12 April, he saw a consultant at the Aintree Cardiac Centre. The consultant noted that he had also been seen by other doctors recently and advised that he should be seen by the cardiac clinic in a further three months.

41. On 15 April, Prison Doctor C noted that he was worried as a member of the IMB had asked him whether he would move to HMP Forest Bank. My investigator has not found any other record suggesting that he might have been moved to Forest Bank. A member of the IMB told the investigator during his opening visit that he had built up a good relationship with him and visited him a number of times in healthcare. He said that he had discussed the possibility of a move to a hospice with him but that he rejected the idea. The member said that he believed he wished to die in prison.

42. The hospital doctor telephoned Prison Doctor C on 21 April with the results of the CT scan. He explained that the man had a soft tissue mass in the pleural cavity (which surrounds the lungs). The hospital doctor referred him to a consultant chest physician for an urgent appointment. On 26 April, he went back to hospital for another endoscopy.

43. On 30 April, he again reported feeling unwell. Another course of antibiotics was prescribed for a chest infection but, later the same day, healthcare staff took a call from the hospital (the name of the person was not recorded) advising that an urgent appointment had been made for 6 May as it was possible that he had lung cancer.

44. The prison chaplain arranged to telephone his brother on 4 May. Prison Doctor C spoke to him and explained that his brother was in poor health and that further investigations were being done. The doctor offered to answer any further questions from his brother.

45. The man next went to hospital on 6 May, when he was seen by a consultant at the chest clinic. The consultant did not think that he was fit enough for any surgical intervention, but said that he would raise his case at a multidisciplinary (MDT) meeting. In the meantime, the consultant recommended that the amount of diuretics (used to increase urine production) prescribed to him were increased. He had previously complained about an increase in the amount of diuretics he had been prescribed.

46. On 13 May, the consultant telephoned Prison Doctor C and explained that the MDT meeting had recommended that the man be admitted to hospital for radiotherapy and "fine tuning of oxygen therapy". The doctor received another telephone call later the same day from a Macmillan nurse (Macmillan nurses provide specialist palliative care), who told him that the man had only weeks to live. The nurse asked for him to be told of the diagnosis that day, and said that she would visit the following day to arrange further care.

47. The nurse visited Altcourse with a consultant in palliative care. The man agreed that the planned transfer to hospital would not benefit him, and that his symptoms could be better managed in prison. He was described as shocked when told that he had, at best, only a few months to live.

48. Healthcare staff continued to monitor him. On one occasion, in the early hours of 17 May, he was found on the floor of his cell, and staff gave him some pain killers and toast. The next day, Prison Doctor C discussed the possibility of hospice care with him, but he remained adamant that he wished to remain at Altcourse where he felt safe.

49. On 19 May, his brother visited him (his transport to and from Altcourse was arranged by the prison), and Prison Doctor C talked to him about his brother's care.

50. By the next day, 20 May, staff noticed that his condition had started to deteriorate. A nurse spoke to a Macmillan nurse about ways in which they could

make him more comfortable as he had developed a pressure sore on his left hip. Two district community nurses visited Altcourse the next day and agreed to order another pressure relief mattress, which arrived later that day. They also left a syringe driver (a small pump used to administer fluids to a patient), to enable staff to administer fluids. Staff continued to look after him, but noticed that he was struggling to swallow and sometimes appeared to be choking.

51. At 8.35am on 23 May, a nurse went into his cell, and thought that he had died. She called Prison Doctor A, who examined him and confirmed his death at 9.02am.

52. Following his death, prison staff visited his brother to inform him that his brother had passed away. The prison made arrangements to collect his brother to take him to the funeral and then take him home. The prison paid for the funeral and he was cremated at line with the family's wishes.

53. The brother told my family liaison officer that he was very impressed with the care shown to him and his brother and described the prison staff as extremely kind. He said that he was shown "kindness beyond belief" by the staff at Altcourse.

54. Both prison family liaison officers attended a full debrief on returning to the prison after informing the man's brother of his death. Notices were issued to all prison units to inform the prisoners of the death. Staff were informed by notices placed in staff areas and on reception.

ISSUES

The man's medical treatment at HMP Altcourse

55. The clinical reviewer undertook a thorough clinical review into the medical treatment the man received at HMP Altcourse. In the summary of his report, he states that the man had a number of significant health problems which were identified during the health screening during his reception into the prison. He confirms that the man was diagnosed as having advanced lung cancer in May 2010, and that he was referred to consultant.

56. The man missed one follow-up hospital appointment in August 2009. This appointment was to check on his progress following the removal of a lesion in June, but was cancelled after no escorts were available. During their inspection early in 2010, inspectors found that, in December 2009, 68 out of a planned 76 appointment were kept. The eight cancelled appointments occurred because other prisoners took priority. They described the appointment system as being "generally well-managed" with "good systems" in place. I am satisfied that the appointment missed by him was a single error and so I do not make a recommendation.

57. The clinical reviewer concludes that appropriate care was put in place and the man's family was kept informed. He judges that the care he received at HMP Altcourse was robust and comprehensive. He describes it as an adequate standard and says that his death could not have been prevented.

Referring the man to a mental health nurse

58. Shortly after his arrival at Altcourse, the man saw a mental health nurse as this was his first time in prison. This was followed up with a referral to a counsellor to help him cope with his first period in custody. I regard this intervention as good practice. The early stages of custody are difficult for many prisoners, but especially for elderly prisoners who have not been in prison before. He confirmed that this approach helped him to adapt to prison life.

The referral to the mental health team and counsellor for an elderly, first-time prisoner is good practice.

Bruising to the man's wrists

59. On 8 March, the man returned to the prison having been to hospital for treatment. Nursing staff at the prison noted bruising to his wrists. My investigator spoke directly to the Head of Safer Custody at Altcourse, about this. He told the investigator that the man's skin was very thin and was very easily bruised by the handcuffs used when escorting him to and from hospital.

60. The risk assessment still required that restraints be used. However, on subsequent occasions, bandages were applied to his wrists to protect his skin. I am satisfied that this was a suitable arrangement which fulfilled the prison's duty to prevent prisoners escaping whilst ensuring that his skin remained intact.

Liaison with the man's family

61. The man's brother told my family liaison officer that he was very happy with the care being shown to his brother, that prison staff were extremely kind and that he was comforted by the treatment his brother received. Staff at HMP Altcourse also arranged to transport him to the prison for a visit prior to his death. This reinforces the positive comments made about the prison's approach to managing his illness and is to be commended.

62. I understand that the man's brother has written to the Director of Altcourse thanking his staff for their kindness in caring for him and his brother.

The standard of family liaison provided is an example of good practice.

CONCLUSION

63. The man was in poor health at the time he came into prison in 2007. His health deteriorated and, from late 2009, he remained permanently in the healthcare centre when his condition demanded full time care.

64. In his clinical review the clinical reviewer comments that the prison kept his health under continuous review and the plans to meet his healthcare needs were robust and comprehensive. He concludes that his death was not avoidable and that the care he received at HMP Altcourse was of an adequate standard.

65. My investigation confirms that the staff at HMP Altcourse showed him and his family compassion and dignity in his final days. It is to the prison's credit that the family liaison staff acted sensitively in their dealing with his next of kin. I make no recommendations in my report.

GOOD PRACTICE

1. The standard of family liaison provided is evidence of good practice.

2. The referral to the mental health team and counsellor for an elderly, first-time prisoner is good practice.