PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2012, at St Catherine's Hospice, Chorley, while a prisoner at HMP Wymott

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 the report of an investigation into the death of a man at HMP Wymott. The man died of cancer at St Catherine's Hospice, Chorley in July 2012. I offer my condolences to those affected by his death.

One of my investigators conducted the investigation. A clinical reviewer was commissioned to provide a clinical review of the standard of healthcare that the man received when he was at Wymott. The prison cooperated fully with the investigation.

The man experienced chest and abdominal pain during his time at Wymott. He declined to attend an appointment with a gastroenterologist but was later admitted to hospital and diagnosed with a malignant stomach ulcer. He was discharged from hospital to await the results of further tests, but was readmitted to hospital because he was in so much pain. He underwent surgery on a perforated gastric mass and liver metastases were found. A referral was made to a local hospice and the man moved there when a bed became available. He died less than three days later.

I consider that the clinical care the man received at Wymott was appropriate and at least comparable to that he could have expected in the community. Although the man was diagnosed with terminal cancer with a short life expectancy, it does not seem that the possibility of compassionate release was discussed with him. I am also concerned that when the man was taken to hospital, restraints were used which were not fully justified by risk assessments which appropriately considered his age, state of health and mobility.

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 **March 2013**

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SUMMARY

1. The man was sentenced to six years and eight months in prison on 26 September 2011. The man was held at HMP Altcourse until 3 February 2012 and did not require any healthcare intervention during this time. On 3 February, he transferred to HMP Wymott.

2. A routine health assessment was completed when the man arrived at Wymott. The nurse noted that he suffered from peripheral vascular disease and blocked femoral arteries, and that he experienced pain when walking.

3. The man suffered chest and abdominal pain on 14 February. He also felt nauseous and had vomited. An appointment with a doctor was arranged for the same day, but the man did not attend. On 21 February, he saw a nurse in the chronic heart disease clinic, and complained of indigestion-like pain in his chest at night. Six days later, he saw a doctor who diagnosed gastritis (a condition which involves the lining of the stomach becoming inflamed and irritated). A blood test showed normal results.

4. On 16 March, the man again saw a doctor and complained of abdominal pain. He was referred to a gastroenterologist but did not attend the subsequent appointment in early May. In May and June, healthcare staff observed that the man appeared thin. On 20 June, a nurse examined his abdomen and found no masses or distension, and no enlargement of the liver, spleen or kidneys. The man was given a diet, fluid and daily weight chart to be completed by carers on the wing. The next day, a doctor again examined his abdomen and found no evidence of a mass, but made a referral to hospital as he suspected cancer. On 22 June, another doctor found that the man was dehydrated and needed to be taken to hospital.

5. The man remained in hospital until 3 July. He underwent a gastroscopy which showed a malignant stomach ulcer. A sample was sent off for histology tests. The man returned to Wymott, but was admitted to hospital again on 8 July as he was suffering from excruciating abdominal pain. The next day, he underwent surgery as a gastric mass had perforated. Liver metastases were found during the surgery. On 13 July the man was told that he had a life expectancy of two to three months and would receive palliative care. Prison staff made a referral to a local hospice on the same day, in accordance with the man's wishes.

6. The man remained in hospital until 27 July, when he moved to St Catherine's Hospice. He died in the early hours of 30 July.

7. We are satisfied that the man received appropriate care. However, we are concerned that an escort chain was used to restrain him when he was taken to hospital on 22 June. We make one recommendation about the risk assessment process.

THE INVESTIGATION PROCESS

8. One of my investigators arranged for notices about the investigation to be posted at HMP Wymott inviting staff and prisoners to contact him with any relevant information. Nobody came forward in response.

9. Another investigator, visited the prison on 31 July 2012 and collected records the man's records on behalf of the first investigator.

10. One of the Ombudsman's family liaison officers (FLOs) contacted the man's son to explain the purpose of the investigation. The man's son did not have any concerns which he wished the investigation to cover.

11. A clinical reviewer was commissioned to conduct a review of the man's clinical care while in custody her review is annexed to this report.

12. HM Coroner for Lancashire will receive a copy of this report.

HMP WYMOTT

13. HMP Wymott is a category C prison holding up to 1,174 adult male, sentenced prisoners. I wing, where the man lived, is a specialist unit for older prisoners who are given additional support to help them with their social care needs. Healthcare services at Wymott are commissioned and provided by NHS Central Lancashire. A private company provides general practitioner (GP) services and out of hours medical cover and clinics are run every weekday morning and two afternoons each week. There are no inpatient beds, but nursing cover is provided 24 hours a day.

HM Inspectorate of Prisons

14. The most recent inspection of Wymott was a short follow up inspection in November 2011 of a full inspection in October 2008. Inspectors commented that:

> "There had been considerable improvements in the care of older prisoners and those with disabilities. I wing continued to operate as a specialist unit, and older prisoners and those with disabilities were supported by health services staff and specialist social care workers. Formal care plans were drawn up for those who needed them and a range of adjustments had been implemented as required. A day care centre had been developed and provided a range of activities for older prisoners and those with disabilities."

15. In relation to healthcare inspectors noted that staffing levels were sufficient, but that that prisoners waited too long to see the GP. :

Independent Monitoring Board (IMB) report

16. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. In their annual report for 2010/2011, the IMB commented about I wing and the care of older prisoners:

> "The Board considers I Wing accommodation to be generally unsuitable for elderly and some disabled prisoners, particularly for the many who spend a considerable amount of each day within its cramped confines. However, the opening of the day care centre during the previous reporting year provides an excellent area for out-of-cell recreation and relaxation. Wing staff also try to ensure that prisoners have access to the exercise yard throughout the day and not simply during the prison's defined association hours."

Previous deaths in custody at Wymott

17. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, we have investigated 34 deaths at Wymott, of which the majority were due to natural causes. This is, in large part, due to its older population

profile compared to most prisons. In a recent report, we made a recommendation about the use of restraints. We repeat that recommendation here.

ISSUES

The diagnosis of the man's terminal illness

18. The man was at HMP Altcourse between 26 September 2011 and 3 February 2012. During this time he did not see healthcare staff. When he transferred to HMP Wymott on 3 February, Nurse A completed a routine health assessment and noted that he suffered from peripheral vascular disease and blocked femoral arteries. Although he had undergone surgery, the man continued to experience pain when walking.

19. On 14 February, Nurse B responded to an emergency call as the man was suffering from chest pain. This had subsided to a dull ache when she arrived. The man reported lower abdominal pain and a feeling of nausea. He said he had vomited clear fluid, and had passed black stools two days earlier. The nurse arranged for the man to see a doctor the same day, but he did not attend the appointment.

20. Nurse C saw the man in the chronic heart disease clinic on 21 February, when he complained of pain to the left side of his chest at night, which felt like indigestion. The nurse listed the man to see prison Dr A on 27 February. The man told the doctor he had felt unwell for two weeks and was constipated, although he had passed stools normally for the previous two days and that discomfort had gone from his gastric area. The doctor diagnosed gastritis (a common condition which involves the lining of the stomach becoming inflamed and irritated) and did not prescribe any treatment. He advised the man to speak to healthcare staff if he felt worse. The next day, the man provided a blood sample and tests for fasting blood lipids, glucose, urea and electrolytes, liver function and blood count were carried out. The results were all within normal limits.

21. On 16 March, the man saw Dr B and again complained of abdominal pain. The doctor referred the man to a gastroenterologist. Three days later, he saw Nurse A and said he was constipated and was not passing urine properly. An appointment was made for the man in the nurses' clinic so that his weight and blood pressure could be monitored. He attended the clinic on 26 March and weighed 53.7kg. He was given an appointment for one month later and advised that dietary supplements would be considered if he had not gained weight.

22. The man was taken to the gastroenterology department at the Royal Preston Hospital on 3 May, but he would not wait to be seen by the doctor and said his symptoms had subsided. On 21 May, he saw Dr B who noted that he appeared thin. The man refused to see a nurse practitioner on 28 May to have a blood sample taken.

23. Nurse D saw the man on 20 June. He said that he had experienced pain in his upper and lower abdomen from the previous evening. Nurse E also examined the man and was concerned that he was very thin. The man said he could not swallow food because he had pain. Nurse E examined his

abdomen and found no masses or distension, and no enlargement of the liver, spleen or kidney. A prescription was given for nutritional drinks, and a diet, fluid and daily weight chart were taken to the wing for completion by the specialist carers on the wing. He was listed to see the doctor two days later. Wing staff were advised to seek medical assistance if his condition deteriorated.

24. The next day, Dr C was asked to see the man, as a carer was concerned about his lack of energy and his low fluid intake. The doctor examined the man's abdomen and found no evidence of a mass. He also examined his prostate, and found that it was enlarged but with no indication of malignancy. He made a referral for the man under the two-week rule for suspected cancer diagnosis. On 22 June, Dr B saw the man, and noted that he was dehydrated and that there was a need to exclude a cancer diagnosis. He was admitted to Chorley Hospital that day.

25. On 29 June, the man underwent a gastroscopy (a procedure using a flexible tube to view the stomach with a camera). On 3 July, the hospital informed prison healthcare that the man had a 'malignant [cancerous] stomach ulcer' and that they were awaiting results from the gastric biopsy. The man was informed of his diagnosis and discharged from hospital.

26. The clinical reviewer had no concerns about the man's preliminary diagnosis. He saw members of healthcare staff at the prison, and referrals were made appropriately. The man refused to attend a number of appointments, most significantly with the gastroenterologist at the Royal Preston Hospital on 3 May. However, in response to continued concerns around his pain and weight loss, he was referred under the two-week rule on 21 June. The initial diagnosis was given ten days later, with further tests to be completed on the biopsy sample.

Informing the man about his condition and treatment

27. The man was informed about his condition by hospital staff. He returned to Wymott on 3 July. The next day, Nurse A saw him and confirmed that he was aware of his diagnosis. The nurse manager talked to him and noted that he was philosophical about his condition, and was not in pain. She discussed his diet and fluid intake, and requested a soft diet to help him eat.

28. When the man returned to Wymott on 3 July, he was awaiting the results of histology tests to determine the exact nature of his condition and treatment options. On 8 July, he was seen by Nurse F after complaining of excruciating abdominal pain. The man said he had not eaten for the previous few days, had drunk only a small amount of fluid, had felt nauseated and had vomited clear liquid. He said he had not asked to see healthcare staff because the symptoms had been intermittent and he felt he had been able to cope. The man was taken to Chorley Hospital's accident and emergency unit by ambulance and was admitted to the hospital.

29. The next day, 9 July, the man underwent surgery. A gastric mass had perforated and a gastro jejunostomy was performed. (This involves the surgical creation of an opening in the stomach to connect it to the upper portion of the small bowel or small intestine, so that a tube can be placed in the opening. The tube allows medications and nutritional liquids to be given through the tube directly into the stomach.) It was noted during the surgery that, in addition to the mass found during the gastroscopy, the man had liver metastases.

30. The man was alert and orientated two days after surgery. He was reportedly cheerful and not in pain although was unaware of his full diagnosis and poor prognosis. On 13 July, a doctor at the hospital informed the man that he had a life expectancy of two to three months. He was offered palliative care.

31. We are satisfied that the man was appropriately informed of his diagnosis. His initial diagnosis was given after the gastroscopy, and a further diagnosis and prognosis was given during his recovery from surgery. The man was made aware of his short life expectancy.

The man's medical appointments and treatment

32. The majority of the man's medical appointments at Wymott were in response to his needs rather than scheduled. Occasionally he did not attend planned appointments, most notably with the gastroenterologist.

33. A two-week referral for suspected cancer cases was made, but was superseded the next day when the man became unwell and was taken to hospital.

34. After he was admitted to hospital for a second time on 8 July, the man underwent surgery and remained there until 27 July. During this time, healthcare staff at the prison remained in contact with hospital staff about the man's condition. Preparations were made for his possible discharge from hospital and a referral was made to St Catherine's Hospice.

35. There were no concerns about the man's medical appointments and treatment. Although he missed some appointments, this was because he chose not to attend them. He received treatment at Wymott and during hospital admissions as appropriate.

The man's pain relief and medication

36. Before the man's diagnosis, he told healthcare staff at Wymott several times that he had chest and abdominal pain which was sometimes severe or excruciating. When examined, the man often said that the pain had subsided. When Nurse F saw him on 8 July, she noted that he appeared to be in great discomfort and he was admitted to hospital.

37. Pain relief during the man's hospital admissions was administered and reviewed by hospital staff. In the last few days of his life, the man was subject

to the Liverpool Care Pathway (approved by the Department of Health as the best practice model for end of life care provision) and pain relief was administered using a syringe driver.

38. The clinical reviewer did not have any concerns about the man's pain relief and medication.

Liaison with the man's family

39. When the man was diagnosed during his second stay in hospital, the hospital informed his daughters who subsequently visited him. Staff at the hospital contacted one of the man's daughters on 21 July to update her about his condition. She said she would inform the rest of the family.

40. When the man died in the early hours of 30 July, a member of staff from the hospice telephoned one of his daughters to inform her. Later that morning, Senior Officer (SO) A, the prison's family liaison officer, telephoned to offer support and discuss the handling of his possessions. The SO talked to the man's son on 1 August. They spoke about the funeral arrangements and whether his family wanted staff from the prison to visit them. The man's son confirmed that the family did not require any further involvement from prison staff.

41. We are satisfied that staff at Wymott liaised appropriately with the man's family.

The man's location

42. During his time at Wymott, the man lived on I wing. Although he was elderly and frail, he was mobile and able to care for himself. Carers on the wing were able to assist him as required.

43. After his first period in hospital, the man returned to the prison and lived on the same wing. When he was admitted to hospital a second time and underwent surgery, it was clear that he would have greater health needs and a possible move to HMP Preston which has an in-patient unit was discussed. In the event, the man moved to a local hospice.

44. We have no concerns around the man's location. He initially lived on a wing with the assistance of carers. His needs were subsequently met at the hospital and hospice.

Compassionate release

45. On 13 July, the nurse manager, informed the prison's senior management of the man's prognosis, and that he wanted end of life care in a hospice. It was agreed that he could be referred to a local hospice. When he moved to the hospice he was released on temporary licence. The man had been diagnosed with cancer on 29 June and informed that he had only two to three months left to live on 13 July, but there was no record that the possibility of

compassionate release was considered. We accept that the man died more quickly than expected after the 13 July prognosis, and it is also possible that he might not have met all the criteria for compassionate release. Nevertheless, we consider it is important that option of compassionate release is considered and documented. We make the following recommendation.

The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

Palliative care plans

46. The man's end of life care was facilitated at Chorley Hospital and, in the last few days of his life, at St Catherine's Hospice. Due to his poor prognosis, the Liverpool Care Pathway was implemented. This is recommended by the Department of Health as the best practice model for end of life care provision.

47. The man's end of life care was administered by the palliative care team and Macmillan nurses at the hospital, and by staff at the hospice. In accordance with the policy, medication other than pain relief (and in the man's case, a nebuliser) was discontinued. He continued to be fed using a jejunostomy tube until his condition deteriorated further. Pain relief medication was administered using a syringe driver.

48. The clinical reviewer had no concerns about the palliative care provided to the man and we are satisfied it was in line with community provision.

Restraints, security and bed watch

49. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

50. The man was admitted to hospital on 22 June and remained there until 3 July. Before being transferred from the prison to hospital, a risk assessment was completed. This detailed the man's ability to escape and level of risk to the public. He was assessed as being of low risk to the public, staff, hospital staff and of escape, but of high risk to children. An escort chain was used and the

man was accompanied by two prison officers. The chain was removed at the request of hospital staff during periods when the man had to undergo treatment. The bed watch logs and management security checks were completed as required, and an updated risk assessment was completed on 27 June.

51. Given the man's age, frailty and lack of mobility, it is difficult to see how two escort officers would not have been sufficient to allay any potential risk he posed to children. Nor is it clear how the risk assessment reached the conclusion about his risk to children, taking into account the court's view that a distinction needs to be made between risk when fit and risk when seriously ill.

52. After being admitted to hospital for a second time on 8 July, the man underwent surgery the next day. He was accompanied by two officers but, after having surgery, the chain was not reapplied. He remained free from restraints and consideration was given to whether the man could be accompanied by a single officer. However, on 23 July, when he apparently attempted to throw items at a nurse, the escort chain was reapplied. The man remained restrained by an escort chain until 27 July, when he moved to St Catherine's Hospice. While we understand the wish to protect hospital staff we do not consider that restraints should have been used for these reasons and certainly the length of time they continued to be applied was not justified. Such use of restraints for misdemeanours would not be acceptable in a prison inpatient unit and neither should they be in a hospital assessment.

53. The man was accompanied by a single officer while at the hospice, and the chain was removed. We are pleased that the man was unrestrained when he died but are not satisfied that the earlier assessments for the use of restraints were justified. We have recently raised this issue with Wymott in a similar case and repeat the recommendation here.

The Governor and Head of Healthcare should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

CONCLUSION

54. The man was sentenced in September 2011. From February 2011, he complained of chest and abdominal pain, and was seen by health professionals within the prison. He declined to attend an appointment with a gastroenterologist at the hospital. In May and June, staff noticed that the man appeared thin and seemed to be losing weight. He underwent a gastroscopy in June which showed a malignant stomach ulcer. During emergency surgery in early July, liver metastases were observed. The man remained in hospital until 27 July, when he was transferred to a local hospice. He died on 30 July.

55. We are satisfied that the level of care that the man received was equivalent to what might have been expected in the community. However, the possibility of compassionate release did not appear to have been considered and we are also concerned that restraints were used when the risk assessment did not appear to take full account of the man's condition.

RECOMMENDATIONS

1. The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

   The recommendation was not accepted for the following reason: "HMP Wymott understands and accepts the need to refer prisoners with terminal illnesses for compassionate release. However, we are not accepting the recommendation because, at the time of his death, we were in the process of determining the man's suitability for release."

   The prison provided an email exchange as documentary evidence that compassionate release was being considered. This exchange took place on 17 July 2012 between the man's offender supervisor (based in the prison) and his offender manager (a probation officer in the community). There seemed to be some confusion about the process involved in making an application for release on compassionate grounds, and the email exchange provides no evidence that such an application was considered by the prison's management or by the Release and Recall Section (RSS). The investigator spoke to the offender supervisor, who was not aware of any formal application being made.

   The investigator spoke to a member of the prison's management team. She explained that a conversation would have taken place about the best way to facilitate the man's end of life care, and that compassionate release was one of the options to consider. On this occasion, however, a supervised release on temporary licence (ROTL) was thought to be the most appropriate option. She went on to say that decisions were based on a prisoner's risk of harm as well as his health. She acknowledged that the consideration was made verbally and that there was no written account of the man being considered for release on compassionate grounds.

   It is important that the considerations and any risk factors that contribute to the decision are fully documented. If an application for compassionate release is not sent to the RSS because a prisoner is not considered suitable, this should be documented. For this reason, the recommendation has been retained in the report.

2. The Governor and Head of Healthcare should ensure that risk assessments for hospital escorts take into account up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

   The recommendation was accepted. The Head of Healthcare had undertaken an audit of ten further risk assessments and PERs, and formulated an action plan which included raising awareness amongst healthcare staff, the development of examples of completed risk assessments, and for reception nurses to deliver further training to all nursing staff involved in completing risk

assessments. Sample checks of completed risk assessments and PER forms will be conducted on an ongoing basis.

Decisions to apply restraints are made taking full account of the information contained in the healthcare risk assessment, security information, and any dynamic risk factors.