Circumstances surrounding the death of a man at Shepton Mallet Community Hospital, while in the custody of HMP Shepton Mallet, in September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

April 2009

This is the report of an investigation into the death of a man at Shepton Mallet Community Hospital on 23 September 2008, while in the custody of HMP Shepton Mallet. The man was 45 years old and had been terminally ill for some time. I would like to offer my condolences to the man's family for their loss and to all those who were touched by his death.

The investigation was conducted on my behalf by one of my investigators. I also asked Somerset Primary Care Trust (PCT) to conduct a clinical review into the standard of healthcare the man received while in custody. The clinical review was carried out and his report is attached in full as an annex. I would like to thank the Governor of Shepton Mallet and his staff for their co-operation and assistance with the investigation. I am particularly grateful to staff for making all the practical arrangements for my investigator.

The man had been diagnosed with a malignant melanoma (the most serious type of skin cancer with a high risk of spreading) in March 2008. Further tests in April confirmed that the melanoma had spread and was affecting his lungs. In addition, the man experienced symptoms of headaches and unsteadiness, which further tests in June confirmed to be caused by a lesion on his brain. The man was given palliative radiotherapy and transferred to Shepton Mallet Community Hospital on 12 September, 11 days before his death, when his pain could no longer be managed in prison.

I am satisfied that the man received a high standard of care at Shepton Mallet and that staff did all they could to manage his illness effectively. Indeed, there is much within this report of which the Prison Service can be proud.

I make one recommendation, derived from the clinical review. This is addressed to the Primary Care Trust and relates to the "two week rule" in respect of the referral of patients suspected of having a malignant disease. I have also commented on the extent to which decisions on compassionate release are influenced by a culture of risk-aversion.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2009**

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SUMMARY

The man first entered custody on remand at HMP Winchester in April 1987. He was later convicted of murder and sentenced to life imprisonment. He had been in prison custody for 21 years when he died at Shepton Mallet Community Hospital on 23 September 2008. He was 45 years old.

During his more than two decades in prison, the man moved between various establishments. In most of these he had regular contact with healthcare staff. The most significant was at HMP Wormwood Scrubs where he had problems with his stomach and was diagnosed with a hiatus hernia and acid reflux. Following investigation, this condition subsided and the man had no further recurrence of this illness for the remainder of his time in custody. At another prison, the man was diagnosed as an asthmatic but this was managed effectively.

The man arrived at HMP Shepton Mallet in February 2003. On his reception, it was recorded that he had no medical problems. During his first four years at the prison, he was seen regularly by healthcare staff for advice regarding asthma and lower back problems.

In June 2007, having reported sick, the man was seen by a prison doctor. The man had a lesion on his right leg that the doctor felt would benefit from being cauterised and this was carried out during the first week of August. The man then had no further contact with healthcare until 3 September. He had developed a number of lumps, similar to the one that had been removed, which were causing him discomfort. A nurse referred him to the doctor and he was seen the same morning. The prison doctor examined the lumps and recorded in the man's medical notes that he was to have a course of antibiotics and return to see the doctor if they appeared to be getting worse.

The prison doctor next saw the man on 22 October. At this time, the doctor felt that the man would benefit from having an ultrasound scan to determine what the lumps were. The results of the scan were received by the prison on 29 October, and indicated a number of lesions. A further scan was due to be carried out in five weeks but when the prison saw the man again on 3 December, she informed him that she was referring him to a specialist to rule out the possibility of cancer.

Over the next three months, the man underwent a series of further tests. On 19 March 2008, the prison doctor informed him that he had cancer and would require either chemotherapy or surgery later. Subsequent tests revealed that the cancer had spread to other areas of his body. A specialist informed the man on 10 June that the cancer had spread to his brain. He was also told that life expectancy for patients with this type of cancer could be less than six months.

Following the diagnosis, the prison ensured that a care plan was put in place for the man and that he was kept informed about his treatment. He was keen to remain at Shepton Mallet for as long as possible, but had also expressed a wish to be granted release on compassionate grounds. The prison completed the necessary application

and submitted it on 26 June. In August, the prison and the man were informed that his application for compassionate release had been unsuccessful.

On 12 September, the man transferred to Shepton Mallet Community Hospital as his condition had deteriorated significantly and he required additional support. Over the coming days, his family visited frequently along with staff from the prison. On 19 September, the prison resubmitted the application for the man to be released on compassionate grounds. However, although the decision was favourable, it arrived too late. The man died in his sleep on 23 September 2008.

I have endorsed one recommendation made by the clinical reviewer regarding adherence to the Department of Health's "two week rule" for suspected cancer patients.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 25 September 2008 when he contacted Shepton Mallet to arrange for documentation to be provided. Notices were issued to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. My investigator received one letter in relation to these notices from a prisoner who said he was a close friend of the man. He wrote to praise the actions of staff at Shepton Mallet in caring for his friend. My investigator spoke with him when he visited the prison and he again told the investigator that he felt the man had been well cared for.

2. I asked Somerset Primary Care Trust (PCT) to conduct a clinical review into the care and treatment of the man at Shepton Mallet, in accordance with my terms of reference. The clinical reviewer conducted a report and is attached in full as an annex.

3. The Family Liaison Officer (FLO) from my office spoke to the man's sister on the telephone on 10 and 14 October. My family liaison officer told her about the investigation being undertaken into her brother's death and gave her an opportunity to raise concerns and ask questions. The man's sister identified three issues of concern to her. These were:

    - Compassionate release
    - Escort at the hospital
    - Transfer to Bristol.

4. My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. A copy of the report will be provided to the Coroner to assist with his enquiries and the inquest process.

HMP SHEPTON MALLET

5. HMP Shepton Mallet is the oldest prison in the United Kingdom. Its current role is that of a category C prison holding life sentence prisoners. The prison is divided into four wings with the capacity to hold up to 186 prisoners.

6. HM Chief Inspector of Prisons, Dame Anne Owers, carried out an inspection of Shepton Mallet in June 2008. In her report, Dame Anne said:

> "Shepton Mallet is a small, old prison holding only life and other indeterminate-sentenced prisoners. This short follow-up inspection showed that, in spite of its physical constraints and problems, it continued to provide a safe and positive environment and had indeed improved the amount and quality of activities available. The prison was a safe environment, which was particularly commendable given the range of offences and the freedom of movement within the prison. There was no evidence of bullying, and self-harm was rare. Mandatory drug testing showed the prison to be virtually drug-free."

Shepton Mallet does not provide 24-hour healthcare cover, but in relation to the provision of healthcare Dame Anne's report says:

> "Healthcare services were generally good and professionally delivered. The small team had a broad range of skills and met prisoners' routine clinical needs. Those with more complex conditions were able to get hospital treatment quickly. One nurse had specific responsibility for older prisoners. Chronic diseases management was excellent and well supported by external health professionals. Mental health support was good. Dental services met need and there was only a short waiting list."

7. The Independent Monitoring Board (IMB) at Shepton Mallet published their last report in 2007. In relation to the provision of healthcare services the IMB said:

> "As a lifer only prison the average age of prisoners is, as a consequence, older than in many other prisons. The healthcare department is an integral part of the prison. Due to the older population a high number of prisoners have heart related problems due mainly to the sedentary lifestyle they lead for many years. In support of the care given by the team in healthcare there are regular clinics held by the doctor, dentist, psychiatrist, optician, chiropodist and physiotherapist. All patients are offered regular check ups for hypertension, strokes, diabetes, epilepsy, asthma, obesity and a well man clinic. During the year there have been no complaints submitted using the patient advice liaison service."

8. Since my office took responsibility in 2004 for investigating all deaths in prison custody, there have been three previous deaths from natural causes at Shepton Mallet. Recommendations that I made following these deaths are not repeated in this report.

KEY FINDINGS

9. The man was charged with murder in April 1987. He was remanded into custody and taken to HMP Winchester. On arrival into custody, he was seen by medical staff and admitted to the healthcare wing for observation. This was the normal protocol for prisoners who had been charged with murder, although the man said that he had no suicidal thoughts. At the end of April, he was moved to an ordinary wing where he settled in well.

10. The healthcare team at Winchester assessed the man in July 1987 when he complained of stomach problems. He told the doctor that his general practitioner (GP) had prescribed him medication before he entered prison and he had also had tests but was not aware of the results. Further tests indicated that the man was suffering from acid reflux (this is when acid from the stomach leaks up into the gullet (oesophagus) and may cause heartburn and other symptoms).

11. While on remand, the man had other minor ailments including conjunctivitis (an irritation or inflammation of the conjunctiva, the lining of the eyelids and the whites of the eyes). He also had a number of dental problems that were all treated.

12. On 7 October 1988, the man was found guilty of murder and given a tariff (minimum time to serve before release) of 15 years. He then returned to Winchester and continued to be seen regularly by medical staff for reports to be completed, as well as reporting sick for minor ailments.

13. The man transferred to HMP Wormwood Scrubs on 20 September 1989. The prison doctor reviewed him on 28 September and recorded his previous medical concerns at Winchester. The man's stomach problems were of particular interest to the doctor. He noted in the man's medical file that he had undergone various tests to identify a cause but had not been given an endoscopy (a procedure where the inside of the body is directly examined using a device known as an endoscope). In view of this, the doctor referred him to a consultant who was due to visit the prison.

14. On 3 October, the visiting consultant assessed the man and concluded that his symptoms had been present for five years. Further questioning of the man confirmed that they had not changed recently and there was nothing to suggest anything other than the previous diagnosis of a hiatus hernia (when part of the stomach pushes up into the lower chest through a defect in the diaphragm - the large flat muscle that separates the lungs from the abdomen and helps breathing). The consultant recorded that, should the man's symptoms change, an endoscopy would be advisable. He subsequently underwent an endoscopy in January 1990 that indicated nothing unusual.

15. The man attended healthcare during 1990 when he began to experience blackouts. He reported passing out for up to 30 seconds and, on a number of occasions, he sustained minor injuries as a result. The prison healthcare team, in partnership with Hammersmith Hospital, Cardiology Department, arranged

for the man to undergo tests that included an electroencephalograph (EEG). (An EEG records the electrical activity of the brain. It is a useful test to help diagnose epilepsy.) A computerised tomography (CT) scan was also carried out. (This is a detailed x-ray of the body using computerised images.) The results of all these tests were normal.

16. Regular follow-ups by the healthcare team continued throughout 1990 and into the following year. In May 1991, the man was seen in the prison by a visiting consultant. It was recorded in his medical notes that he had not experienced any further blackouts and he reported that he had been feeling well. There was little contact with healthcare during the man's remaining time at Wormwood Scrubs.

17. On 18 March 1992, the man transferred to HMP Whitemoor. He remained there for two years six months. During this time, he was only seen by healthcare for minor problems. Over the next nine years, the man transferred between HMP Maidstone, Albany, and Grendon and back to Albany. He had contact with healthcare in all prisons, but his most significant problems appear to have been asthma and lower back pain for which he received treatment.

18. The man transferred to Shepton Mallet in February 2003. Healthcare staff recorded his medical history. They then saw him regularly to give him advice in relation to his asthma. He also continued to experience back pain that made it difficult for him to work in certain areas of the prison. His behaviour and conduct in the prison gave staff no cause for concern, and he was popular amongst other prisoners.

19. On 29 June 2007, a second prison doctor saw the man and recorded that he had a lesion (abnormal tissue found on or in an organism) on his right leg. The doctor wrote that it would require cauterising (use of heat or chemicals to stop bleeding, prevent the spread of infection, or destroy tissue) at the next opportunity.

20. Following a minor operation to remove the lesion on 8 August, the man had no further contact with healthcare in relation to this ailment again until 3 September when a healthcare nurse saw him. The man had reported sick as lumps similar to the one removed from his leg had increased in size and were causing him discomfort. The nurse referred him to the doctor.

21. The prison doctor saw the man later the same morning and recorded in his medical notes:

> "Developed two fatty lumps approx one month ago – now enlarged, tender no im injections etc, not diabetic, on examination inflamed, warm slightly tender, non fluctuant lump 5cm x 10cm, ? Infected seb cyst. For course antibiotics, see one week, or see Dr this week if getting worse. If no response will need referral for biopsy in view of rapid growth. No allergies need to check urine for glucose."

22. The man was seen at least once a week for routine blood tests in relation to his other chronic illnesses but no further mention was made of the lumps until the prison doctor saw him again on 22 October. The doctor reviewed the lumps and recorded in the medical record:

> "Review of lumps – now not inflamed, tender, possibly got smaller but ache on exam 4cm x 3cm lump subcutaneous (fatty tissue), left lumbar region plus one smaller one ?cysts ?limpoma – for ultrasound. Form completed."

23. The ultrasound, referred to in the notes above, was completed and the results received by the prison on 29 October. (An ultrasound is a diagnostic imaging technique used to examine internal body structures including tendons, muscles, joints, vessels and internal organs for possible lesions or other abnormalities.) They indicated a number of lesions and it was planned to repeat the scan in four to six weeks.

24. Over the next five weeks, the man was seen on a number of occasions by members of the healthcare team for a number of different reasons. However, none was in relation to the lumps. On 3 December, the prison doctor saw the man and discussed the ultrasound results with him. She told him that it was not a limpoma (a benign tumour composed of fatty tissue) and that she would like him to be referred to outside hospital under the two week rule (a referral system used by doctors to ensure that patients who they believe might have cancer are seen by an appropriate specialist within two weeks).

25. The man was examined at the Royal Bath Hospital on 20 December by an orthopaedic surgeon. The surgeon wrote to the prison doctor following the appointment and said that he considered the lumps were likely to be abscesses (a collection of pus). The surgeon said that the man was reasonably fit and well apart from suffering from asthma. Although the lumps had no abnormal features, the surgeon decided that a Magnetic Resonance Imaging (MRI) scan was required and said that he would see the man again once this had been completed. (An MRI scan provides much greater contrast between the different soft tissues of the body than a CT scan, making it especially useful in neurological (brain), musculoskeletal, cardiovascular, and oncological (cancer) imaging.)

26. The MRI scan took place on 22 January 2008. The man attended the surgeon's clinic on 14 February and was told that the scan indicated a mass in his lower back. A biopsy was required to investigate the cause. The surgeon completed the biopsy on 5 March. He had an idea of the likely outcome and informed the prison that the man could potentially require palliative care. The tests confirmed the lump to be a malignant melanoma (cancer) on 17 March, and the surgeon immediately made a referral to a Consultant Plastic Surgeon at Frenchay Hospital, Bristol. The man was not made aware of the diagnosis at this time.

27. The prison doctor spoke with the man on 19 March. She explained the results of the earlier biopsies and told him that he had been referred to the Frenchay

Hospital. The prison doctor also told the man that he was likely to need either chemotherapy or surgery but this would be decided later. The man discussed his personal situation regarding family contact. The prison doctor invited him to return at any time to discuss the diagnosis further with medical staff once he had absorbed the information. The Healthcare Manager, spoke to the man the following day on the wing. She suggested that, if he wished for his sister to attend the outpatient's appointment with him, it could be arranged. However, the man said that he did not feel this necessary at that time.

28. The man continued to be seen regularly by healthcare for INR tests (a system for recording the results of blood clotting tests). On 3 April, he attended the Oncology Department at Frenchay Hospital and it was decided that he should undergo a full body scan to determine the extent of the disease. The man attended Bristol Royal Infirmary on 18 April for a CT scan. A week later, on 25 April, he returned for a biopsy of the mass in his lower back and arms.

29. On 27 May, the man attended a clinic at Bristol Haematology and Oncology Centre to be assessed by a hospital doctor. The doctor confirmed that the results of the biopsy showed the masses to be cancerous. He also told the man that the CT scan taken earlier in April showed that cancer was present in his lung. After the appointment, the doctor wrote to the healthcare unit at the prison. In his letter, the doctor confirmed that the man currently felt well, and that the area where he had the biopsy was healing well. However, he went on to say that the man had expressed new symptoms of unsteadiness and headache. In view of this, the doctor arranged for the man to undergo an urgent MRI scan and return to the clinic in two weeks.

30. During the appointment in May, the doctor had also discussed with the man the prognosis of metastatic melanoma (secondary cancer). He told him that the survival rate was usually less than one year, but if the results of the MRI scan were not favourable this could indicate a shorter life expectancy. The doctor suggested that the man might wish to arrange for his sister to attend all future appointments with him, but also offered to speak with her over the telephone if the man preferred.

31. The MRI scan was carried out on 4 June and the man returned to see the doctor a few days later on 10 June. The doctor told the man that the results showed that the cancer had spread to his brain and was the cause of his worsening headaches. The doctor discussed the treatments that would be used to try and stabilise the man's disease. The doctor also discussed the prognosis in light of these new results. He indicated that, in the majority of cases of patients with this form of cancer, survival could be less than six months. In a follow up letter to the prison, the doctor said that it would be entirely appropriate for the prison to make provision for the man's deteriorating condition. The doctor also indicated that he understood that the man's sister would be able to offer further support if he was to be released from prison. He considered that it would be appropriate for the prison to start any process that would facilitate this. All this information was communicated to the prison. Staff were keen for the information regarding the prognosis to be put in writing as

soon as practicable so that an application for compassionate release could be made.

32. The man was seen a couple of days later by healthcare staff at the prison who provided him with the dates for his radiotherapy treatment. This was to be given weekly starting from 27 June. Pain relief and alternative options were also discussed. The man was prescribed a small dose of Diazepam to be taken for the next two nights as he was feeling low and having trouble sleeping. The man discussed his future with healthcare staff and said that even if he was to be granted a downgrade in security status to category D (this is the lowest security category and would mean that he would be suitable to be held in open conditions), he would prefer to remain at Shepton Mallet for as long as possible. The man said that when his condition deteriorated he wanted to go to his sister in Bristol as she would care for him to the end of his life. This information was recorded for the purposes of the compassionate release application.

33. Over the next few weeks, the man was seen almost daily by healthcare staff as his discomfort and pain increased. Nursing staff and doctors changed his level of pain relief accordingly, and this provided some respite. The prison also referred the man to Dorothy House Hospice in Bradford on Avon. The hospice said that, while the man remained in prison custody, they would be willing to provide advice on pain relief and management. The prison also pursued the letter from the doctor relating to the man's prognosis, which was required for the compassionate release application. It was received by the prison on 23 June and the application submitted promptly to the Early Release Section at the Ministry of Justice on 26 June.

34. On 26 June, the man was also placed on the prison's disability register. This tells staff of those prisoners with particular disabilities and their individual needs. Because of this, the Disability Liaison Officer at Shepton Mallet, spent time with the man discussing his needs and informing him of what could be done to aid his day-to-day activities. In his notes of the meeting, the disability liaison officer said that it was apparent that the man did not want to be a burden to staff or other prisoners, but that he did understand the prison's duty of care. The man's cell location was also discussed as he was on the twos landing (two flights up) and it was becoming increasingly difficult for him to negotiate stairs. The man was keen to remain where he was as he felt that he had a good support structure in place. It was therefore agreed that, at an appropriate point, he would be located on the ground floor of the same wing to maintain that support. The disability liaison officer recorded that the man was very positive, but fully understood that the treatment that he was about to begin was not a cure and that he would eventually succumb to his condition.

35. The man attended his first appointment for treatment on 27 June. On his return to the prison, a nurse saw him on the wing to discuss his sister accompanying him to appointments. The man said that he did not feel this was necessary and that he had been keeping her updated. The nurse also talked about the man's pain relief and the possibility of changing to morphine as well as his longer-term wish. The man told the nurse that, although he would like to go to his sister's

home, he would prefer to die in a hospice. The nurse explained that it was important that his wishes were communicated to the wider team who were looking after him and that his care plan was updated.

36. The nurse told my investigator that the man was likely to require an escort of at least two staff, so a move to a hospice was considered unlikely. The nurse said that the prison had to consider the feelings of other patients at the hospice if the man was moved there. However, a palliative care nurse from Dorothy House Hospice visited the prison on 30 June to offer advice to the nursing staff responsible for the man's care. Arrangements were also made to provide a teaching session for wing staff who were responsible for the man.

37. Over the next few weeks, nursing staff at the prison assessed the man daily and checked his levels of pain relief, making changes where necessary. The healthcare team were also in regular contact with outside agencies, including Dorothy House Hospice and Macmillan nurses, to obtain advice on the man's care. The man's sister also contacted the prison, and discussed at length with the Healthcare Manager the long-term plans for her brother. She expressed her wish for him to be allowed to be cared for at her home. The Healthcare Manager said that she would contact the appropriate department to check the progress of the compassionate release application. The Healthcare Manager also spoke to the matron at Shepton Mallet Community Hospital regarding a bed being made available for the man should it be required. Once moved to the community hospital, the man would receive the same level of care that would otherwise be provided in a hospice.

38. A meeting took place on 22 July 2008 between the Healthcare Manager, the nurse, and a governor to discuss the man's care. In a letter sent by Mr Hunt to the Healthcare Manager, he set out the four areas that had been discussed:

> "Concern that some staff and prisoners may need support as the man's illness progresses. We agreed that weekly informal meetings involving chaplaincy, healthcare, wing staff and prisoners should be held on A wing each Friday at 9.30am.
>
> "We discussed what help could be provided by the Palliative Care Nurse and whether we should commission some staff training.
>
> "We discussed options for pain relief and following a risk assessment agreed that from a security perspective Fentanyl Patches (synthetic morphine) could be safely managed providing suitable control measures are put in place. The patches are self-adhesive and have a minimum dosage of 25 micro grams and a maximum of 100. The patches are a controlled drug and will be checked for compliance daily by healthcare and changed every 72 hours.
>
> "We agreed from a security perspective, options for pain relief will have to be reviewed when Fentanyl Patches cease to deliver sufficient pain relief."

39. At the beginning of August, the prison was notified by the external probation officer that the man's sister's home address had been deemed unsuitable for him to be released to. The prison did not at this stage inform the man but awaited the final decision from Early Release Section. The man continued to receive daily support from wing staff, prisoners and healthcare staff. It was apparent that the pain in his head was causing continued discomfort, but when spoken to by nursing staff he said that he had no fears and he remained mobile.

40. Following an appointment with the doctor at Bristol Royal Infirmary on 12 August, the prison was notified that the man could not be offered any further radiotherapy. He would, however, begin chemotherapy every three weeks. This would have no effect on the lesion on the man's brain but would help with the tumours elsewhere. The nurse spoke with the man on his return from the appointment and recorded that he was "shell shocked". She visited him again the following day when he appeared to be calmer.

41. On 20 August, the nurse met the man's sister at the prison. She provided a full update on the speed and progression of the man's illness and the management plan put in place by healthcare. The governor also spoke to the man's sister to discuss the non-medical aspects of her brother's care, and explained that a final decision had yet to be made by Early Release Section on the compassionate release application. The nurse recorded that the man's sister was appreciative of the time that had been provided to explain things to her.

42. Over the next week, the man's condition was reported by wing staff to be noticeably getting worse. He had failing mobility and his fine motor skills were deteriorating. However, wing staff were grateful for the support provided by the hospice team. On 25 August, the man mentioned to nursing staff that he felt he had experienced a fit in the early morning as his tongue was bruised. He expressed concern about losing control of his bodily functions if this happened again, and was told that medications could be prescribed if necessary.

43. The man was informed on 28 August by the governor and the nurse that the application for compassionate release had been unsuccessful due to the home circumstances being unsuitable. The nurse saw him the following day. She told him that she had spoken to his sister and informed her of the decision. The man reported that he had not slept well, but was now feeling very tired so was returning to bed.

44. At a multi-disciplinary team meeting, held on the man's wing on 5 September, staff discussed resubmitting an application for compassionate release. The team also looked at the number of staff that would be required to escort the man if he needed to be admitted to outside hospital, as well as his level of care and support. In addition, support for other prisoners, particularly those close to the man, was also discussed.

45. The man began to use a Zimmer frame to aid his mobility. On 8 September, The nurse recorded that he had decided not to go ahead with chemotherapy and to cancel all the appointments. The man also spoke to the nurse about

resuscitation and said that, in the event, he did not wish to be resuscitated. The man said that he had had enough and felt that he would rather be in hospital. However, the nurse pointed out to him that he had more independence and control while in the prison. When the nurse visited him again the following day, the man appeared much brighter. The nurse recorded that he seemed calm and at peace.

46. Over the next week, however, the man's condition deteriorated further and on 12 September arrangements were made for him to be transferred to Shepton Mallet Community Hospital. The prison kept the man's sister informed of his condition and notified her of the transfer.

The man's transfer to Shepton Mallet Community Hospital

47. The man was transferred to Shepton Mallet Community Hospital by non-emergency ambulance at 6.00pm on 12 September. He was escorted by two prison staff but was not restrained. On arrival at the hospital, the man was placed in a side room. The Healthcare Manager visited the man shortly after he had been admitted. He slept through the night and was settled. The escorting staff remained in the room with him. The next morning, the man did not feel like eating the food he was offered, but was taking fluids. Later that afternoon, his sister and brother visited and stayed with him for an hour. He remained settled for the remainder of the day and had another reasonable night.

48. Staff recorded in the bedwatch log that the man was polite and courteous when they attended to him the following day. Despite encouragement from both the escort staff and nurses, he continued to eat very little and spent large parts of his day sleeping. The healthcare nurse visited the man during the afternoon. He also had visits from both the prison chaplain who came several times, and the resident hospital chaplain. During the late afternoon, the man's sister rang the hospital. She spoke with nursing staff and her brother, but their conversation only lasted about two minutes as he was very tired. Nursing staff continued to encourage him to eat, but he declined and only drank water. The man had another quiet night.

49. On 15 September, the escort staff were told by the nursing sister that the man was unable to walk unaided and this was likely to remain the case. In view of this, the staff contacted the prison so that the risk assessment could be reviewed. The Healthcare Manager visited the hospital later in the morning and recorded in the man's medical notes that he recognised her and seemed quite bright. He was not eating much and would drift in and out of sleep. The prison again completed an application for the man to be released on compassionate grounds due to the deterioration in his condition. At 1.00pm that afternoon, the escort was reduced to one officer in light of the information regarding the man's mobility. At around 6.00pm, the man was given some soup, which he managed to eat, after which he slept for the remainder of the night.

50. The next day, the man remained settled and the bedwatch log shows that he again spent the morning dozing and ate very little. However, at 2.00pm a

Senior Officer contacted the escort staff and informed them that they would revert to a two-officer escort. The reasons are not recorded in the log. However, an entry in the man's medical record by the Healthcare Manager gives the reason as concerns raised by hospital staff about the number of rest breaks the escort officers were having. They reported that on one occasion they had found the man trying to get out of his bed while the officer was on a break. (My investigator was unable to confirm the exact details with the hospital and, apart from the entry by the Healthcare Manager, there is no other information.) The man was given a hot meal at teatime and attempted to eat some food. He then slept and, although restless during the night, the escort staff raised no concerns.

51. Over the next few days, the man's condition remained the same. His family and members of the prison chaplaincy team visited him. Nursing staff continued to encourage him to take food and he would eat a small amount but was unable to manage any more. On 19 September, Nursing Sister Frost told the escort staff that, following a visit by Governor Bugdale the previous day, they would be happy for the escort to be reduced on the condition that the officer remained in the room when the nursing staff were in close contact with The man. As a result, at 2.00pm the escort was returned to a single officer. The Healthcare Manager visited The man again later that day and recorded in his medical record that he was slowly deteriorating. His sister had also visited but they were unable to hold a conversation as he drifted in and out of sleep. The compassionate release application was re-submitted to the Early Release Section. Due to his deteriorating condition, The man was catheterised that afternoon. Nursing staff attended to The man as required to make him comfortable, but he continued to sleep for the remainder of the day.

52. The man's condition continued to deteriorate slowly over the next couple of days and, on 22 September, the Healthcare Manager contacted the hospital for an update on his condition. The Healthcare Manager was informed that the hospital had initiated the Liverpool Care Pathway (LCP) for end of life care (the LCP ensures that dying patients are cared for in the same way regardless of the setting). The Healthcare Manager and the nurse visited the hospital later that day to see the man. The man's eye movements indicated that he appeared to recognise their voices. It was recorded in his medical notes that the man's sister and brother were with him and had been at the hospital all day. His family said that they felt it would not be long before he passed away and they planned to visit again the following day. During the visit, The Healthcare Manager explained to the man and his family that the papers for compassionate release had been re-submitted and they were hopeful that he would be released. The staff felt that he understood what he was being told.

53. The following morning, both the Healthcare Manager and the prison chaplain visited for a short time. The hospital contacted the man's sister as his condition had deteriorated further and she arrived at 12.00 noon. An intravenous line was put into the man, as he was unable to take his medication orally. The man's brother arrived at the hospital at 5.15pm. The Healthcare Manager and the nurse visited again but stayed only a short while. The man's sister left the hospital at 6.10pm and his brother remained until 8.15pm. Nursing staff

continued to check on the man, and at 11.10pm it appeared that he had stopped breathing. The Deputy Matron checked for signs of life and it was apparent that the man had passed away peacefully in his sleep. The doctor confirmed his death at 11.45pm.

Events following the man's death

54. A second Governor visited the hospital at 11.50pm and spoke with the officer who had been on duty at the time of the man's death. The Governor asked the officer how he was feeling and offered counselling if required.

55. The Deputy Matron telephoned the man's sister to inform her of his death. The Governor spoke to her the following morning to offer the condolences of prison staff and to offer support. The Governor also invited the man's family to visit the prison in order to speak to staff and prisoners who knew their brother.

56. The Governor also wrote to the man's sister on 26 September. In his letter, he expressed his disappointment that the decision on compassionate release had not been made in time for the man to pass away as a free man. The Governor added that he had also hoped for this, as it would have made it unnecessary for the added distress of an Ombudsman's investigation and Coroner's inquest.

57. The prison chaplain officiated at the man's funeral on 6 October. This was attended by the Governor and other members of staff from Shepton Mallet. The prison chaplain also held a memorial service for the man at the prison so that prisoners had the opportunity to pay their respects.

ISSUES

58. The man's family mentioned three areas of concern that they wished to be examined during the investigation process. I address these first in the following section of this report.

Compassionate Release

59. The man's sister expressed concern at the length of time that it had taken for the compassionate release application to be considered. She said that she had found the system very closed and difficult to understand for someone not connected to the prison system. The man's sister told my Family Liaison Officer (FLO), that she was angry the system was not flexible enough to respond to such a rapid deterioration in someone's health.

60. My investigator, contacted the Early Release Section in the Ministry of Justice. This is the department responsible for considering and responding to all applications for compassionate release. My investigator asked the caseworker who dealt with the man's application to clarify three points that he considered to be the main issues for the man's family:

- Is there an agreed timescale for responding to a request for compassionate release? If so what is it?

- What were the reasons for the initial refusal in August 2008?

- Was the man finally granted release and, if so, what additional factors in the second application influenced this?

61. The case worker responded to each of my investigator's questions:

- Since life expectancy for prisoners suffering from terminal illnesses can vary significantly, there is no set timescale for consideration of a compassionate release request. However, these cases are treated as a matter of urgency and are considered as soon as is possible. Depending on the specifics of the case, the Public Protection Casework Section will need to seek guidance from several different departments or organisations including Prison Service Medical Advisors, the Probation Service, the Parole Board, and Senior Ministers.

- In order for a compassionate release to be considered, all of the following criteria must be met:

    - The prisoner is suffering from a terminal illness and death is likely to occur very shortly, or the prisoner is bedridden or similarly incapacitated (for example, those paralysed or suffering from a severe stoke).
    - The risk of re-offending (particularly of a sexual or violent nature) is minimal.
    - Further imprisonment would reduce the prisoner's life expectancy.

- There are adequate arrangements for the prisoner's care and treatment outside prison.
- Early release will bring some significant benefit to the prisoner or his/her family.

In the man's case, at the time of the initial application it was not judged that these criteria had been met. The Probation Service did not support compassionate release and had several concerns, including that the man had not fully addressed his offending behaviour whilst in custody and that he still maintained that the murder of his victim was accidental. Consequently, it was assessed that his risk of harm was higher than minimal and that it would not be appropriate to release him into the community without a period of testing in open conditions.

- The man had indeed been granted compassionate release in response to the second application. Sadly, he had died before the final approval from Ministers could be obtained. At the time of the second application, the Public Protection Casework Section had been told that the man's condition had substantially deteriorated, and that he was now bed-bound with a life expectancy of one or two weeks. It was thought that this level of physical incapacitation, which had not been present at the time of the initial application, meant that his risk of re-offending had been reduced to a level where he could be safely released.

62. The issue of compassionate release and the timeliness of decisions have been frequently raised by families in my investigations into deaths of terminally ill prisoners. I entirely understand the frustration of families who attempt to understand the process. It must seem to them to be long and unnecessary, when all they want is for a loved one to be released and be free to die without the intrusion of escort staff. However, I also understand that the process is designed to ensure that an informed decision is made and that the protection of the public is fully considered. I hope that the answers provided by the case worker enable the man's family to understand the process better and the reasons behind the decisions. However, like most such decisions that I review, the reasons were extremely risk-averse. By August 2008, the man was already very ill and had limited mobility. The degree of risk he posed to the public was frankly negligible. While I appreciate the concerns raised by the Probation Service, they had to be balanced against the man's then state of health, and the rate at which it was deteriorating. The decision of the Early Release Section not to recommend release in August was not unreasonable in the circumstances. But it is not hard to see how a different decision could have been reached in a more risk-neutral climate.

Escort Arrangements

63. The man's sister stressed to my FLO that she could not fault the behaviour of the escort staff who accompanied the man at the hospital. However, she questioned whether it was necessary for there to be two staff on duty (although this was later reduced to one). It was also a concern that the staff remained in the same small room with the family, and the man's sister thought the staff

themselves were embarrassed by this. My investigator asked the prison to provide the reasoning behind this decision. The Governor replied as follows:

> ”The escort does have to be in the same room at all times. The staff have to be close enough to actively supervise the prisoners at all times. If the prisoner needs to use the toilet, the staff have to go with him to check the area before it is used and then remain immediately outside of the door. If there are two staff on the escort then one has to be physically attached to the prisoner usually by the escort chain but this means the member of staff must be only a few feet from the prisoner.
>
> “A full risk assessment must be carried out on any prisoner going out of the prison. A decision then has to be taken on whether the escort should be one or two officers. Only in exceptional circumstances would more be required. In this case, the man was still considered a danger to the public and mobile enough to escape. As he became immobile, the situation was reviewed and the escort reduced to one officer. In these circumstances, no restraints are used but the officer has restraints available if required for emergencies. The man had to have an escort of at least one officer, as it is not possible to grant a temporary release to a life sentence prisoner in Category C conditions such as Shepton Mallet. The only other way for the man to have the escort removed was for him to be granted compassionate release which had been applied for on two occasions.”

64. I am grateful to the Governor for supplying this response to the questions posed by my investigator. Here too I feel that decisions were very risk-averse. It seems extremely unlikely that the man had the inclination or desire to escape from custody given his advanced illness. However, I also understand that decisions that involve protecting the public are a matter of fine judgement. What is critical is that the prison ensures a balance between public protection and the compassionate management of seriously ill or dying prisoners. I am satisfied that in this case the level of security was not unreasonable.

65. I understand that the close proximity of staff, the man, and his family, in a small room might have been embarrassing for all concerned. However, it would not have been right for such a consideration to have affected the risk assessment and the level of escort thus determined.

Transfer to Bristol

66. The man’s sister had hoped that in the later stages of her brother’s illness, he could be moved to a hospice in the Bristol area, and she had expressed these wishes the prison. She was told that the journey would be too arduous for him. However, she felt that the prison had been reluctant to sanction this move due to financial constraints and asked my investigator to provide clarity on this decision. My investigator asked the Governor about this and was provided with the following response:

> “I was not aware of a request by the man’s sister to have her brother transferred to a hospice/hospital closer to her home. I am sure that if

the request had been made we would have tried to arrange it with the PCT. I would not have allowed the issue of cost to come into it. If the PCT could have arranged it I would have ensured that from a Prison Service point of view it was carried out as required."

67. Following the issue of the draft report, the man's sister said that her concerns about the costs being an issue came about as a result of two conversations she had with the Head of Healthcare the month before her brother died. She said that the Healthcare Manager had told her the prison might not support a transfer to Bristol for the man due to financial implications of providing escort and bedwatch cover. However, the man's sister also said that during the second conversation, The Healthcare Manager raised concerns regarding the impact the journey to Bristol would have on her brother, and she said that she did have sympathy with this view.

68. My investigator found that, as part of his palliative care plan, prison staff had consulted the man regularly about his preferred place to be cared for and spend his last days, and his responses had been recorded. The man had said that he wanted to go to his sister's home but preferred to die in a hospice, although he did not express a preference as to where this should be. The decision to move the man to Shepton Mallet Community Hospital for his end of life care was made with his full involvement in all decisions.

Care at Shepton Mallet

69. During the investigation, the community ethos at Shepton Mallet was evident in all areas of the prison environment including healthcare. It is clear from the medical notes that staff from all areas, as well as prisoners, had been involved in making the man's illness more manageable and making him comfortable. The compassion shown by all those who dealt with the man is to be commended. For example, staff called in to see the man in hospital on their way to and from shifts. The prison also arranged for discipline staff who were looking after the man on a daily basis to have training in caring for him and support. This highlights the excellent multi-disciplinary approach taken by Shepton Mallet in dealing with a dying prisoner. I am sure it was a comfort for the man knowing that he had that level of support. It also ensured that he remained in an environment where he knew people for as long as was possible.

70. The Governor and staff should be proud of the professionalism and sensitivity they displayed. I would be grateful if the Governor shared that view with his staff.

Clinical review

71. A number of matters have been highlighted by the clinical reviewer most of which I reproduce below:

> ”We shall never know if the lesion that was cauterised on the man’s leg 13 months before he died was the source of the malignant melanoma that killed him. Experts may disagree with me but my belief is that the disease must have spread long before the cautery for it to cause visible, palpable lumps three weeks later. The prison doctor did not know that it was a melanoma at that stage and her approach seems to have been the one I would have followed and she is to be commended for
>
> a. ordering an ultrasound at an early stage
> b. arranging an urgent appointment rather than the repeat ultrasound that was recommended.
>
> “From what I have read and heard the man’s quality of medical care seems to have been good. However, it worries me that having been referred by his GP as potentially having a cancerous problem in early December that it was not until late May that he actually received any treatment for his problem.
>
> “Specifically the areas of delay seem to have been:
>
> - The two-week rule was not adhered to; being referred on 3 December meant he should have been seen by 17th, not 21st December.
> - Four weeks between consultation and the receipt of the scan report seems overly long in the circumstances, the ‘Festive Season’ not withstanding.
> - And a further three weeks before a decision that a biopsy was needed is surprising.
> - And a further three weeks wait for an ‘urgent’ biopsy does not fit with my understanding of the word. This was because the man’s blood pressure, a long-standing problem which he had often chosen to ignore, was moderately raised. But it feels as though no one thought to ask the anaesthetist if they would proceed despite the raised blood pressure but blindly followed the guideline that blood pressure should be controlled before surgery. Guidelines are just that, not inviolable laws.
> - I do not know if a two-week delay between biopsy and the result being available is reasonable but it seems a long time to me. The result of the first biopsy was reported much sooner
> - More than five weeks delay before the surgeon’s referral to the plastic surgeons was acted on seems very long
> - Why there was a further two-week delay before he was referred to the oncologists is hard to understand when a perfectly good tissue diagnosis was available in March. I cannot see why there

was a need to wait for confirmation from the plastic surgeons' pathologists.

"Fortunately, the oncologists responded with commendable speed, seeing the man within three days of referral.

"Despite the above delays, I do not believe it made any difference to the fact that the man died when he did. Melanoma, when it spreads, as it had a year before his death, is a dreadful disease that often fails to respond to any therapy. But to know that it would not respond meant it had to be tried and I would be happier if he had been afforded treatment sooner. Once he came to the attention of the oncologists the man's care seems to have been good.

"As I have said, Malignant Melanoma is an unpleasant cancer whose symptoms are difficult to control. Sadly this seems to have been the case but the doctors and nurses at the prison healthcare centre, together with their custodial colleagues, seem to have done all they could to alleviate his suffering within the confines of a prison cell. They

- sought advice from the hospice
- negotiated with the oncologists
- tried to secure his release from prison on compassionate grounds
- discussed his wishes with him frequently
- arranged his transfer to hospital when they could no longer care for him in prison and arranged a host of amenities to make his life more comfortable.

"But it must have been challenging to provide palliative care in prison with the restrictions on the use, for example, of syringe drivers and inadequate space for a hospital bed and ripple mattress, all of which would be seen as a standard part of palliative care in the community."

72. The clinical reviewer makes the following recommendation which I endorse:

The PCT should ensure that Bath Hospitals are adhering to the 'Two Week' rule of seeing patients suspected of having malignant disease within a fortnight.

73. The clinical reviewer does not believe that the delays mentioned in his review made any difference to the progress of the man's disease. However, he considers that if the man had not had to live with this uncertainty it would have been better for his emotional state. In his review, the clinical reviewer also comments that no one person appeared to be responsible for ensuring that the man's problems were addressed with appropriate haste. Had there been such an individual, some of the delays might have been reduced. I acknowledge the clinical reviewer's comments but consider that, on the evidence available, the team at Shepton Mallet did everything in their power to facilitate speedy intervention at every stage following the man's diagnosis.

Conclusion

74. The man's death had a considerable affect on both prisoners and staff in the small community of HMP Shepton Mallett. The efforts made by healthcare staff to engage with a range of people in an attempt to make the man's illness more manageable is commendable. It is unfortunate that compassionate release could not have been effected sooner, but I consider that prison staff did all they could to chase this matter up. The man's sister also acknowledged the support and help she had received following her brother's death. She said that she was able to draw some comfort from the fact that her brother had been well liked by both staff and prisoners.

RECOMMENDATION

1. The PCT should ensure that Bath Hospitals are adhering to the 'Two Week' rule of seeing patients suspected of having malignant disease within a fortnight.