Investigation into the circumstances surrounding the death of a man in hospital in November 2006 whilst in the custody of HMP Leeds

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report into the death of a man aged 72 at HMP Leeds. The man died of lung cancer in hospital in November 2006. A post mortem was not requested.

I offer my sincere condolences to the man's family and friends. The man bore his treatment and ailing health with dignity.

The investigation was conducted by one of my colleagues. I am grateful to the Governor of Leeds and his staff for their co-operation. I would also like to thank the medical officer of Leeds Primary Care Trust for providing the clinical review into the man's care and treatment.

The man suffered very poor health. Consequently, he spent his time in custody in the prison's healthcare centre. He also frequently attended hospital for kidney dialysis. On 25 October 2006, he was admitted to hospital. Following further investigation, the man was diagnosed on 10 November with inoperable lung cancer. In view of the nature of his offences, and the rapid deterioration in his condition, the man was not considered for release on compassionate grounds. He remained in hospital under observation by prison officers. His family were at his bedside when he died.

The man was one of a growing number of elderly prisoners who enter prison with challenging chronic illnesses. His family's primary concerns were that he had often complained of pains in his legs and that, despite frequent treatment in hospital, his cancer was not detected earlier. I concur with the clinical reviewer that the man's care and treatment were appropriate and, in most respects, of high quality. I also accept that, even though an early x-ray might have detected the man's cancer, it would not have altered the final outcome.

I make three recommendations, two of which are drawn from the clinical review and concern the management of complex clinical cases like this one. The third recommendation is designed to promote effective communication between a family and healthcare when there are concerns over a prisoner's health.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man died in hospital in November 2006. He was 72 years old.

The man had been received into HMP Leeds on 5 March 2004, following his conviction for offences which had taken place over 30 years previously. This was his first time in prison. Prior to custody, the man had a history of serious and life threatening illnesses and had been in very poor health for several years. These ailments included duodenal ulcers, diabetes, angina, stroke, and chronic renal failure for which he required frequent kidney dialysis.

In the months prior to his death, he had complained of pains in his legs. This was diagnosed as sciatica and treated with analgesics and physiotherapy. On 25 October 2006, he was taken to hospital for dialysis treatment. Due to concerns about the control of his diabetes and the slowness of his recovery from dialysis, he was admitted as an in-patient. Following further tests, the man was diagnosed with inoperable lung cancer.

The man's family were not made aware of his prognosis until two days before his death. Consideration was not given to releasing him on compassionate licence despite his rapidly deteriorating condition.

In hospital, the man was supervised by prison officers and initially handcuffed. However, in light of his condition and the poor prognosis, the prison decided to remove the handcuffs and keep him under discreet observation to afford him some decency and privacy. His family were able to visit him in hospital and were at his bedside when he died. The Coroner did not request a Post Mortem as the outcome had been expected.

The clinical review found that the man's care was appropriate and generally of high quality, with a good level of communication between prison health and hospital staff. Although an early x-ray might have identified the presence of cancer, this would not have altered the outcome. The review recommends that prison healthcare staff at Leeds review their approach to the overall management of patients who have complex clinical issues, and audits this case with a view to learning lessons for the future.

My report notes the family's concerns about the absence of a convenient and identifiable mechanism for contacting healthcare in the event of anxiety about a prisoner's health.

THE INVESTIGATION PROCESS

1. I appointed one of my colleagues to conduct the investigation on my behalf. He first contacted HMP Leeds on 4 December 2006. The Governor and his staff produced the man's core record and a number of other documents for examination.

2. Notices were issued to staff and prisoners informing them of the investigation and giving them the opportunity to speak with my investigator. There was no response to these notices.

3. The Leeds Primary Care Trust was commissioned to conduct a clinical review into the care and treatment of the man at Leeds.

4. One of my family liaison officers contacted the man's next of kin and other family members to offer them the opportunity to meet her and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions. The investigator and the family liaison officer met the family on 18 January 2007. The family had a number of concerns:

    - They wanted to know why the man's cancer had not been detected sooner, particularly in the light of his lengthy treatment in hospital, his repeated complaints of pains in his legs and back, and his weight loss.
    - They believed that language difficulties may have hindered communication and that staff could not acknowledge his discomfort.
    - The family were also concerned that the man was denied the use of a wheelchair in prison. They recall that he was made to walk to the visits room which took a lot of time and effort and was distressing to watch.
    - The man had also told them that on several occasions he had fallen in healthcare and staff had been slow to assist.

5. The family also told my investigator that they felt that there was no easy mechanism to alert healthcare staff to their concerns about the man's deteriorating health. They were also upset with some of the officers who had been deployed on bed watch duties. They said they had found them to be insensitive and indifferent to the man's circumstances, and perfunctory in their dealings with the family.

6. The investigator wrote to Her Majesty's Coroner to inform him of the nature and scope of the investigation. A copy of the report will be sent to the Coroner to assist with his inquiries.

HMP LEEDS

7. Leeds is a category B local prison, built in 1847. It accepts adult male prisoners from courts in West Yorkshire. The prison has an operational capacity of 1,254 prisoners and always functions at or near this figure. It was expanded from four to six wings in 1994. The prison has 680 cells, plus rooms and wards for 26 patients in the healthcare centre.

8. HM Chief Inspector of Prisons last inspected Leeds in August 2005. She identified that the prison faced a number of difficult challenges because of chronic overcrowding and a high turnover of prisoners.

9. Prisoners who need to receive hospital treatment are escorted by prison staff. For the duration of a prisoner's stay in hospital, a member of the prison's management team visits daily to ensure that the restraint protocols are being followed by the bed watch staff. Prior to conducting the 'daily management check', the designated manager is provided with a bed watch Risk Assessment / Management Check form by the Security Department. This sets out the arrangements against which they can make their checks.

10. Since the Prisons and Probation Ombudsman assumed responsibility for investigating deaths in prisons in April 2004, there have been 22 deaths at Leeds. Six of these have been attributed to natural causes.

EVENTS LEADING UP TO THE MAN'S DEATH

11. The man complained of pain in his legs in January 2006. In consultation with the hospital, the prison's healthcare centre adjusted his painkillers. The medical record shows that on 7 March the man was referred to the physiotherapist because of continuing pain in his right leg. A diagnosis of sciatica was made. No x-ray was taken, but the man continued to receive physiotherapy.

12. In July 2006, the man again complained of pain in his left leg and was seen by the prison doctor. Records show that an x-ray was not carried out on the basis that he would not have been suitable for surgical intervention. It was decided to continue to treat his symptoms with painkillers and physiotherapy. On 30 August, the man was seen again by the prison doctor because of pains, this time in his right leg.

13. On 22 September, consideration was given to the possibility that the man's continuing health problems might be attributable to prostate cancer. Blood tests were carried out, but nothing abnormal was detected. An x-ray of the right hip was arranged but there is no evidence that it was ever carried out. The clinical review found that x-rays which could have ruled out or confirmed the presence of cancer had not been undertaken.

14. On 24 October, the man suffered an episode of hypoglycaemia (deficiency of glucose in the blood) for which an ambulance was called. However, his condition was stabilised with glucose and he did not need to be taken to hospital.

15. The following day, the man was taken to hospital for his dialysis treatment, supervised by two prison officers. However, following the dialysis, he was admitted to a ward as there were concerns about the control of his diabetes, his response to dialysis treatment and his general health. He remained in hospital for observation and pending further investigation. (His hospital notes for the period from 25 October to 17 November 2006 were unavailable and therefore not examined during the course of the clinical review as they appear to have become separated from his main notes.)

16. Throughout his stay in hospital, prison staff maintained bed watch logs. On 26 October, the log indicated that the man's wife attended the prison to visit her husband and was told that he had been kept in hospital. She was allowed to visit him in hospital under constant supervision.

17. On 27 October, the log showed that the man would require a Magnetic Resonance Imaging (MRI) scan and would need to spend a further period of time in hospital. He was taken to the Infirmary for the MRI scan on 31 October. On 3 November, a doctor told the man that he would require a further scan.

18. The log showed that by 6 November that the man was unable to walk and there was difficulty in locating a vein for continual dialysis treatment. The record also recorded that at 1.30am on 9 November he was uncomfortable and in pain, for which he was given a morphine injection.

19. On 10 November, the man had a Computerised Topography (CT) scan (this produces a cross section image of the head and body which is then analysed by computer). The scan showed that he had lung cancer and that it was spreading.

20. The consultant told the man on 13 November that tests had shown that he had a growth in his lungs. At about 8.30pm on that evening, a relative telephoned to ask if they could visit him outside of normal visiting hours in order to avoid other members of the family. The visit was authorised.

21. On 17 November, the man was seen by a palliative care nurse to help control the pain in his legs caused by spinal cord compression. This was treated with medications that to some degree compromised his diabetic care. Owing to the damage the cancer had caused to his spine, the man was unable to walk. His family told my investigator that they only learnt of the real extent of the man's condition two days before he died, denying them sufficient time to come to terms with the news. In view of the poor prognosis for recovery, the Governor withdrew escort staff from his bedside in order to afford him a greater degree of privacy and dignity. However, visits were discreetly supervised. The family commented on what they perceived as the indifference and insensitivity of some of the escorting staff, saying that some officers did not think to give up their chairs to visitors and often left litter beside the man's bed.

22. On 28 November, the man was seen by orthopaedic surgeons who considered that surgical intervention was not appropriate. The man also developed problems with his arterio-venous fistula used to attach him for dialysis treatment. By 29 November, it was impossible to continue kidney dialysis.

23. On 29 November, a priest and a number of family members visited the man. He had developed a chest infection and, in consultation with his family, medical staff deemed that further active treatment was not in his best interests. By 6.00pm, his condition had deteriorated, and at 9.30pm escort staff were advised by the hospital to contact the man's next of kin to inform them of the situation.

24. At 3.40am on 30 November, the bed watch log shows that the man was given an injection of morphine to make him comfortable. At about 5.50am, with his wife and son at his bedside, he was pronounced dead.

EVENTS AFTER THE MAN'S DEATH

25. Following the man's death, the escort officers informed the control room and duty governor by telephone. The Governor was told at about 6.14am. Leeds implemented its contingency plan for a death in custody, informing the National Operations Unit (NOU) and the Independent Monitoring Board (IMB). A Prison Family Liaison Officer (FLO) was appointed. Staff who had cared for the man were told of his death and offered the support of the prison's care team.

26. The man's funeral took place on 7 December, attended by some members of the prison healthcare team. The prison offered to pay towards the cost of the funeral.

27. The family told my investigator that contact with the prison was formal and perfunctory. The man's son said that, a short time after the funeral when he attended Leeds to collect his father's property at the prison's request, he was made to wait at the front gate for a period of time. The family perceived this as insensitive and discourteous.

ISSUES CONSIDERED DURING THE INVESTIGATION

Management of physical health and renal failure

28. The Leeds Primary Care Trust undertook a clinical review of the man's care at HMP Leeds. The focus was to find out why his cancer had not been detected at an earlier stage, particularly as over a period of time he had complained of pains in his back and hips and had lost a lot of weight. The review concludes that the man had a complicated medical history with several seriously life-threatening conditions and that, in general terms, his care was appropriate and in most respects of high quality. There appears to have been close and effective communication between prison healthcare and the specialist hospital services, particularly in relation to the management of his renal failure.

29. The review establishes that the man had complained of pains in his legs and had been treated for sciatica. These symptoms continued against a background of deteriorating health. The possibility of cancer was eventually considered, although blood tests for this were negative. The review also found that the man did not appear to have had an x-ray although his renal failure would have warranted such investigation. The clinical reviewer says that an x-ray of the spine may have confirmed or excluded bone abnormalities, but even though an earlier x-ray could have identified the cancer as an underlying illness, it would not have altered the outcome.

30. The review concludes that in the man's case an overall care plan to ensure effective coordination and denote responsibility for action might have been helpful. It recommends that prison healthcare at Leeds should review how it approaches the overall management of complex clinical issues and that a clinical audit of the management of the man's case should be undertaken to identify lessons for the future.

    The Governor and Healthcare Manager should review the overall management of complex clinical cases.

    The Healthcare Manager should undertake a clinical audit of the management of this case to identify lessons for the future.

31. The man required regular kidney dialysis for his chronic renal condition. Records indicate that he went to hospital over 400 times for this essential life-saving treatment. Staff said that towards the end of his life the continual treatment was taking its toll on him and he was taking longer to recover.

32. The man was engaged in a daily battle to survive when he entered prison, and it seems that his degenerative physical conditions were difficult to manage irrespective of the environment he was in. He was therefore located in the healthcare centre where he could receive appropriate intervention and support. Staff established a good relationship and rapport with him, and I am content that there was reasonable communication and understanding between the parties. However, I note that when the family became concerned about the man's deteriorating health and weight loss, they felt frustrated that there was no

The Governor and the Healthcare Manager should develop an auditable policy to promote an effective means of communication between family members who have concerns about a prisoner's health to alert the appropriate member of healthcare.

33. The man found it difficult to walk, but had the use of a walking stick as well as a wheelchair when he required it. He was treated with the appropriate painkillers and physiotherapy for the pains in his legs and hips. He was also encouraged to walk short distances in order to maintain some degree of mobility and independence. Although his family was understandably distressed to see him walking to attend visits, I am content that the efforts made by staff to encourage him to use his legs were in his best interests. I also note that, when the man was becoming less able to walk, arrangements were made for him to receive his visits on the ground floor of the healthcare centre. My investigator has been told that the Healthcare Manager has since drawn up a new policy to ensure that prisoners with mobility problems can get to the visits area safely and in a timely manner.

Diagnosis of lung cancer

34. The man had been complaining of pains in his legs since January 2006. This was unusual as his family describe him as a man who was not prone to complain about pain or discomfort. In March 2006, the pains in his legs continued, and he was initially diagnosed with sciatica and treated with painkillers and physiotherapy. In September, the man was still complaining of pains in his legs and hips. At this time, doctors felt that he might be suffering from prostate cancer. His blood tests were normal, although he did not have an x-ray to confirm or rule out the presence of cancer. I note that in July a decision was made not to x-ray him on the basis that he was not deemed suitable for surgical intervention because of his poor health. Family and staff have commented that the man had noticeably lost weight and found it longer and more difficult to recover from his thrice weekly dialysis treatment. I also note that, despite his regular attendance in hospital, further tests were not conducted on the man in order to determine the cause of his leg and hip pain. The clinical review indicates that an x-ray of the spine might have confirmed or excluded bone abnormalities. However, as I have said earlier, it concludes that while an earlier x-ray might have identified the cancer as an underlying illness it would not have altered the outcome.

35. On 10 November 2006, following a series of tests, the man was diagnosed with inoperable lung cancer which had spread. By 29 November, his deterioration was such that dialysis treatment, upon which he was totally dependent, became impossible to maintain. The man's rapid physical deterioration was such that there was little time to arrange for his release on compassionate grounds. Whilst I note that his family are upset that they were not made aware of his prognosis until two days before his death, I judge that it was not the responsibility of HMP Leeds to disclose this information.

Escort staff

36. The man attended hospital very frequently during his sentence. From 25 October until his death, he was supervised by a number of different prison staff and handcuffed in compliance with Prison Service procedures. When his condition deteriorated, his handcuffs were removed and staff told to maintain discreet observation. The family have suggested that staff were sometimes perfunctory or insensitive but the entries in the bed watch log are professional and courteous. I hope they faithfully represent what actually took place. It can be difficult for staff to establish and sustain meaningful interaction with a prisoner or family with whom they have little or no previous knowledge. But there can be no justification for insensitivity.

37. In regard to the family's complaint that some of the escort staff refused to give up their chairs when visitors arrived at the man's bedside, or left litter by his bed, my investigator was unable to substantiate these allegations. However, I draw them to the attention of the Governor who will wish to ensure that staff are properly aware of the professional standards they are expected to uphold at all times.

RECOMMENDATIONS

The Governor and Healthcare Manager should review the overall management of complex clinical cases.

The Prison Service responded:

Accepted. This has been reviewed but is felt that it is difficult to define 'complex' case as all the patients on the in-patients department have multiple healthcare needs. There is not a systemic problem with managing them well via our multidisciplinary team. This is acknowledged by the clinical reviewer who comments that the care provided had been 'in most respects of a high quality'. Although the installation of the clinical IT system onto the department may enhance the system established.

The Healthcare Manager should undertake a clinical audit of the management of this case to identify lessons for the future.

The Prison Service responded:

Partially accepted. The doctors responsible for the man's care have discussed this case and believe the joint management of the man, who was seen 3 times a week at the hospital, to have been of a good quality. Communication broke down over X-rays and bloods, which were requested of the hospital. The lesson learnt is that in future all requests will be both written and verbal.

Doctors will continue to speak where appropriate to their colleagues within the secondary care system when sharing the care of a patient.

The Governor and the Healthcare Manager should develop an auditable policy to promote an effective means of communication between family members who have concerns about a prisoner's health to alert the appropriate member of healthcare.

The Prison Service responded:

Not accepted. The department has a very open, easy style. Relatives of all patients have access to staff, indeed in this case staff spoke to family over the period the man was resident on the unit. Whilst in secondary care staff of the prison healthcare unit cannot second-guess the information that might be given to family by hospital staff. If family member have issues with information flow whilst the man was a patient in hospital then this should be taken up directly.