Investigation into the circumstances surrounding the death of a man at a local hospice in January 2010, while in the custody of HMP Leeds

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of the investigation into the death of a man, who died at a local hospice on 6 January 2010. At the time of his death the man was in the custody of HMP Leeds. I offer my sincere condolences to the man's family.

The investigation was carried out by an investigator on my behalf. I would like to thank the Governor of Leeds and his staff for their co-operation.

Leeds Primary Care Trust (PCT) commissioned a doctor to review the clinical care the man received while at Leeds. I am grateful for his thorough and considered review.

The man arrived at Leeds in 2008 with a number of existing health problems, which were well managed by the prison's medical staff. However, in January 2009, he complained of a cough, which doctors thought was due to a chest infection. The symptoms worsened and, by the end of April, he had been diagnosed with inoperable lung cancer. He was released on temporary licence to a local hospice during December, returning briefly to the prison when his condition improved, where he died on 6 January 2010.

The clinical reviewer and I conclude that the clinical care the man received following the diagnosis of cancer was of a high, and sometimes excellent, standard generally equitable to what he would have received in the community. Staff should be commended for their thoughtful, compassionate and individualised approach to the man's care.

I endorse three of the clinical reviewer's recommendations made to the Head of Healthcare at Leeds concerning the management of illnesses.

The final version of the report reflects the National Offender Management Service's response to the recommendations made. This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **October 2010**

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SUMMARY

The man was remanded into the custody of HMP Leeds in January 2008, charged with a number of sexual offences he was alleged to have committed some 20 years earlier.

On his arrival, the man told prison staff he was a Jehovah's Witness and that he had never been in prison before. He said that he suffered with a number of existing medical problems which were being treated in the community. The man was examined by a doctor and prescribed his regular medications.

In April 2008, the man was convicted of the offences and sentenced to ten years imprisonment. Over the following months, the man's long term health conditions were monitored by prison healthcare staff. His appointments at local hospitals were also facilitated.

The man first complained of chest pains and coughing up brown phlegm in January 2009. He was diagnosed with a chest infection and prescribed antibiotics. The symptoms continued and he was prescribed a second course of antibiotics in March.

However, by the end of March, the man was complaining that his phlegm was now blood stained. He was asked to provide a sputum sample, which indicated no ongoing infection. A week later, he was examined by the doctor who referred him for a chest x-ray. The results indicated a mass in his chest, and the man was told that he had lung cancer.

The hospital consultant treating the man suggested that he undergo a special type of scan. However, partly because the man was an Irish citizen and did not have an NHS number, this could not be arranged. Alternative tests were performed which showed that the cancer had spread and was inoperable.

The man told medical staff that he did not want to receive a blood transfusion or be resuscitated. He wanted to be kept comfortable and said he would prefer to die in a hospice. In December 2009, the prison applied for the man to be released on temporary licence to a local hospice, to take place when medical staff deemed it necessary.

On 18 December, prison healthcare staff decided that the man could no longer be cared for in the prison and he moved to the hospice. His condition improved sufficiently that he returned to the prison on 24 December. However, by 5 January 2010, the man had become confused and disorientated. He was again released to a local hospice, where he died the following day.

The clinical review of the care the man received at Leeds concludes that he received a high and often excellent standard of care whilst in prison. I am pleased to report that his treatment was generally equitable to what he would have received in the community. I make three recommendations concerning the processes for recognising and responding to symptoms.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death on 6 January 2010. The investigation was allocated to an investigator.

2. The investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to these notices. The investigator was provided with copies of the prison records relating to the man's time at Leeds, including his medical record.

3. Leeds PCT commissioned a doctor to conduct a review of the clinical care the man received at Leeds. After full consideration of all the documentation provided, the clinical reviewer and the investigator concluded that no formal interviews with staff or prisoners were necessary. However, the clinical reviewer discussed the medical issues relating to the investigation with, one of the prison's doctors involved in caring for the man. In addition, staff helped to answer a number of questions by email.

4. HM Coroner for West Yorkshire was notified of the investigation and provided the results of the post mortem. The Coroner will receive a copy of the report to assist his enquiries.

5. The Ombudsman's senior family liaison officer invited members of the man's family to be involved in the investigation. They raised no specific questions or concerns but I hope this report provides them with a picture of the care he received at Leeds.

HMP LEEDS

6. HMP Leeds is a category B local prison, accommodating just over 1,000 adult male prisoners from the West Yorkshire area. It opened in 1847 and has undergone extensive expansion and refurbishment to improve the Victorian facilities.

7. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. For the past four published quarters, Leeds' performance has been judged "good" (with other possible assessments being exceptional, requiring development or serious concerns).

HM Inspectorate of Prisons (HMIP)

8. HM Chief Inspector of Prisons conducted an unannounced full inspection of Leeds in December 2007. The inspection report noted the prison's "chequered history" and that, while there were "still considerable problems … vigorous management attempts were being made to grapple with them". Although Leeds was still failing to perform sufficiently well against any of the Inspectorate's key areas, progress had been made.

9. The inpatients unit of the healthcare centre contains 20 single cells. In the Inspectorate's survey of prisoners, half described the provision of healthcare at Leeds as good or very good. Those prisoners with life-long health conditions (such as coronary heart disease) were provided care in line with national guidance. The majority of external hospital appointments were kept.

Independent Monitoring Board (IMB)

10. Each prison in England and Wales is also monitored by an IMB, the members of which are drawn from volunteers from the local community. Board members have access to every part of the prison and each prisoner held there. The IMB must produce an annual report, with the latest available for Leeds covering 2009.

11. In their overall judgement, the Board concluded that "HMP Leeds is providing a generally safe environment for prisoners and slowly improving the respect shown to them by staff". However, the Board noted its concern that activities for prisoners had been reduced.

12. The annual report highlighted that the healthcare department continued to be "well managed" and "forward thinking".

Previous deaths at HMP Leeds

13. The Ombudsman became responsible for investigating all deaths in prison from 2004. Since that time there have been 15 deaths from natural causes at Leeds. There are no apparent similarities between either the circumstances of the deaths or the recommendations made.

KEY EVENTS

14. The man arrived at HMP Leeds on 9 January 2008 on remand from court, charged with a number of sexual offences. On his arrival, his mental and physical health was assessed by a nurse. The man said he was registered with a doctor in Ireland and was prescribed medication for angina and high blood pressure (which had damaged his retinas and kidneys), and that he suffered with heart disease. He also reported a family history of heart problems. The nurse recorded that the man had no substance misuse problems, no history of mental ill-health and was not considered to be a risk to himself. The man said he was hard of hearing and visually impaired. The nurse referred the man to see the prison doctor that evening so he could be prescribed his medication.

15. Later that day, the man was examined by a prison doctor. The doctor recorded the man's history of ischaemic heart disease (reduced blood flow to the heart), angina and high blood pressure. He noted that the man was being prescribed a range of medications. The doctor ordered a number of tests and noted that the man's blood pressure needed to be better controlled. He prescribed the man's regular medications for high blood pressure and cholesterol.

16. On 17 January, the man attended the blood clinic for the ordered tests. The results showed a number of abnormalities and an appointment was made for him to see the doctor. The man was told that he had reduced glucose tolerance and needed to diet and take more exercise.

17. The man was found guilty of his offences on 7 April 2008 and was sentenced to ten years imprisonment. He returned to Leeds to begin his sentence. He complained of chest pain the following day. The pain eased after he used his glyceryl trinitrate spray (GTN - commonly prescribed to angina sufferers) and he needed no further medical treatment.

18. Several days later, the man complained of side effects from one of his prescribed medications, valsartan (used to treat high blood pressure). He told medical staff he was under the care of a renal consultant (who specialises in problems relating to the kidneys) in the community. The man said that the specialist had been prescribing losartan instead and he wanted to be prescribed the same in prison. The matter was referred to the prison doctor and, after a review of his medication, the man was prescribed losartan on 25 April.

19. The man was assessed by a nurse on 16 May. He said he had given up smoking one year previously and was using his GTN spray "infrequently". The nurse gave diet and exercise advice.

20. On 11 June, the man had an appointment at the local hospital for assessment of his high blood pressure by a consultant cardiologist. The consultant noted that the man had suffered a heart attack three years previously and had three stents fitted (a small tube fitted into the arteries surrounding the heart to help keep them open). An additional medication was prescribed to help reduce the man's blood pressure, and heart, kidney and ultrasound tests were organised. The consultant advised that the man's condition be reviewed in three months time.

21. The man complained of only minor health problems over the following six months, seeking medical treatment on two occasions. However, on 5 January 2009, he complained of backache and coughing up “dirty phlegm”, which he described as “brownish” in colour. A nurse examined him and found no evidence of a cough or temperature. The man was asked to provide a sputum sample. The medical record notes that he was “demanding to see a doctor” and was told no appointments were available that day. The nurse recorded that her assessment of his condition “did not warrant special sick” (when the prisoner is excused from work or education). According to the records, the man did not provide a sputum sample on this occasion.

22. One week later, on 12 January, a doctor examined the man. He continued to complain of coughing up “dark phlegm” and said he had been doing so for about two weeks. He said he had chest pains on both sides when he coughed. The man told the doctor that he did not smoke but that his cellmate smoked and he had asked to move cells. The doctor recorded that the man had no signs of breathing difficulties and diagnosed him with an upper respiratory tract infection, with muscle pains due to coughing. She prescribed him cough medicine and antibiotics.

23. Over the following few weeks, the man’s blood pressure was checked on nine occasions. Generally, the readings showed improvement. However, on 27 January, the man was examined by medical staff having complained of chest pains during the night. He said he had used his GTN spray but did not call for medical assistance at the time. The nurse recorded that the man had no chest pains at the time of the examination. None of the staff who carried out the blood pressure checks recorded the man having any further chest problems. Indeed, on 25 February, the nurse that had previously seen him on the 5 January recorded that the man reported “no ill feelings”.

24. The man asked for an appointment with the doctor on 19 March as his cough had returned. The nurse requested that he be prescribed a course of antibiotics and a doctor authorised the prescription that day. There is no record of either nursing staff or the doctor examining the man’s chest.

25. A staff nurse examined the man on 31 March, noting that he was experiencing a burning sensation in his chest. He told the staff nurse that his phlegm was now blood stained but denied coughing up any yellow or green phlegm. He was asked to provide another sputum sample, which was sent for analysis on 1 April. The result showed no indications of any disease.

26. The doctor he saw on 12 January examined the man again on 8 April, noting that he had been coughing for some time and was now coughing up blood. The man said he thought the blood was coming from his throat and was getting better. He said his joints were aching. The doctor listened to the man’s chest with a stethoscope, noting that he was wheezing and might be suffering with pneumonia. She referred him to the local hospital for a routine chest x-ray. Two days later, the man told a nurse that he had been coughing up blood during the

night. The nurse recorded that he was “anxious his symptoms were worsening” and tried to reassure him.

27. The chest x-ray was scheduled to take place on 22 April. Two days earlier, the man spoke to healthcare staff, saying he was “very worried” about the appointment. Staff recorded that they had provided further reassurance.

28. The man attended the x-ray appointment as scheduled and the local hospital faxed the results to the prison the following day. The x-ray indicated a mass on the man’s chest, which was likely to be cancer but could also be tuberculosis (TB - a highly contagious disease). Hospital staff advised that the man should be urgently referred for further checks. The doctor he saw initially on 12 January saw him again and completed the necessary referral forms, which were faxed to the hospital.

29. On 24 April, the man asked for the x-ray results. He was told to make an application for an appointment with the doctor. Later that day, the doctor he saw on his first day noted that the doctor he had seen on 12 January would see the man the following Monday (27 April) to discuss the possible diagnosis. During the appointment, the doctor told the man that the chest x-ray had shown a shadow on his chest, which was “quite possibly cancer but could be TB”. The man told her he was “quick to accept things” and that he would not “do anything silly” (meaning that he would not harm himself). He said he would wait until he had a definite diagnosis before telling his children. The doctor noted that she would see him again in three weeks time, following his next hospital appointment.

30. The man was assessed at a local hospital fast track cardiology clinic on 6 May, when he was examined by a consultant respiratory doctor. The consultant arranged urgent tests, a bronchoscopy (when a fibre optic telescope is passed into the major airways taking air to the lungs and shows any blockages) and a computerised tomogrophy (CT) scan (a type of x-ray which provides a more detailed view of the body). Due to the possibility that he was suffering with cancer, his heart treatment was not altered.

31. The bronchoscopy was carried out in hospital on 18 May. A week later, the man told the doctor that he felt “so much better he is convinced it must have been a virus”. On 28 May, he attended an appointment with the oncology (cancer) department at the hospital. During the appointment, the consultant formally diagnosed the man as suffering with lung cancer.

32. The consultant also suggested that the man undergo a positron emission tomography scan. (A PET scan produces a three dimensional picture of the body and its functions. It helps to identify whether the cancer has spread or is operable.) There were significant difficulties arranging the scan, largely because the man, being Irish, did not have an NHS number. At the time, PET scans in Leeds were carried out by a private provider on behalf of the NHS. The company was not able to carry out the scan without an NHS number.

33. There were also concerns about security because the PET scan uses radioactive technology. Any prisoner receiving treatment at an outside hospital must be escorted by prison staff. A number of risk assessments are also made, which consider the risk of the prisoner trying to escape, or harming a member of the public. Following such assessments, prison staff decide whether the prisoner needs to be held in handcuffs or other restraints while out of the prison. The consultant thought it would not be advisable to ask prison officers escorting the man to remain in the room while the procedure was carried out. As a result of the difficulties involved in arranging the PET scan, alternative investigations were carried out.

34. The man began to complain of having trouble sleeping and, on 15 June, asked the staff nurse he had previously seen if he could move to a single cell. She advised him to discuss his request with the doctor and made an appointment for him. Two days later, he saw a locum doctor who recorded that the man would benefit from a single cell.

35. On 29 June, the man saw the nurse prescriber (a nurse who can prescribe medication) who recorded that treating his heart disease was no longer a priority due to the cancer diagnosis. The man told the nurse he was still sharing a cell because he had not received a letter from the doctor confirming that he needed one on his own. The nurse arranged for the letter to be drawn up that day and it was passed to wing staff. In fact, the man remained in the same cell on A wing until he was admitted to healthcare in July. The prison was not able to confirm to the investigator whether he continued to share, or whether his cellmate was moved out.

36. A further entry in the man's medical record that day noted that he did not want to undergo a blood transfusion, due to his religious beliefs. The member of staff recorded that they would inform the hospital of his wishes and that the man understood he would have to complete paperwork to confirm this.

37. Two days later, on 1 July, at 9.30pm, the man complained of coughing up large amounts of fresh blood (known as haemoptysis). He was taken to the local hospital by ambulance. During his stay at the hospital, the man underwent another CT scan. The scan showed that the cancer had spread into both his lungs and the doctors confirmed that surgery was not an option.

38. Hospital staff discussed the man's condition with him. They told him he might only have three or four months left to live and recorded that he was "fully aware" of his diagnosis. The man told staff he was worried about dying from haemoptysis, as his brother in law had. He was told he would not undergo any chemotherapy, but that palliative radiotherapy was an option. (Palliative radiotherapy is intended to treat the symptoms of cancer rather than cure the disease.) While in hospital, the man signed a Do Not Resuscitate order (DNR). It recorded the man's wish not to be resuscitated should his heart stop beating. Staff noted that his concern was to be kept as comfortable as possible. He wanted to be compassionately released from prison (the process by which prisoners can be released from prison early in exceptional circumstances, such as terminal illness).

39. The man returned to prison on 10 July and was located in the inpatients department of the healthcare centre. Following the advice of hospital staff he was given medication to prevent a fatal haemorrhage due to haemoptysis. The man told staff he did not want any intravenous treatment except for midazolam (a sedative).

40. Later that day, the man chose to discharge himself from inpatients and return to the wing, where he said he felt more comfortable. Staff recorded that he would be referred to palliative care specialists in case he was suitable for transfer to a hospice in the future.

41. The doctor he saw on his first day in prison met the man on 20 July and discussed his wishes for the future. The man said he was worried about bleeding to death from haemoptysis and the doctor reassured him that this was very uncommon. The doctor told the man that healthcare staff could treat any symptoms he developed. The man complained of feeling tired and weak and requested sleeping tablets. He said he would prefer to die in a hospice. The doctor told him he could return to inpatients at any time if he wanted to. The doctor suggested that the Macmillan Nurses (palliative cancer care specialists) should be contacted and the man agreed.

42. Over the next two weeks, the man received two doses of radiotherapy. Several of the medications prescribed for his other health problems were discontinued to avoid haemoptysis. The man repeated his wish to receive only palliative care and not to be resuscitated.

43. On 29 July, a Macmillan nurse assessed the man. The nurse suggested that he be prescribed a low dose of morphine because of his persistent cough (which he later rejected, saying it “did not agree with him”). The man was again offered the opportunity to move to inpatients and told that he could be offered more visits from his family and increased privacy at the end of his life.

44. The man continued to go to hospital appointments and, on 24 August, was told that he had a metastasis on his left thigh bone (meaning the cancer had spread). Doctors advised that this would need an operation to place pins in the bone and asked that he be admitted as soon as possible. An appointment was made for 1 September, when the pins were put in place.

45. Staff noted that by 11 September, the man was in less pain and was “feeling reasonably well in himself”. Healthcare staff wrote to wing staff asking for the man to be provided with a more supportive chair. Just over two weeks later, at 3.50am on 28 September, nursing staff were called to see the man who complained of being in a lot of pain. He asked for an increased dose of pain relief medication but was told that only the doctor could authorise such changes. Day staff were asked to pass his request to the doctor.

46. At 4.50am on 2 October, the night nurse was called to see the man who was complaining of generalised pain. The nurse gave him his day’s dose of pain relief medication and tried to reassure him. The nurse also made a written

request for the man's pain relief medication to be changed. At 10.00am that morning another nurse came to assess him. The nurse agreed to ask the doctor to increase the dose of pain relief medication or change to a different medication.

47. The doctor he saw on his first day in prison considered the man's current pain relief medication prescription that morning (four days after he complained of being in pain). He did not examine the man but suggested that the dosage be increased. The man was now taking the maximum possible dose of dihydrocodeine (a painkiller) with additional doses of morphine when the pain was very severe. A nurse visited him the following day, after the prescription had been altered and recorded that the man was experiencing less pain and "looked well".

48. However, on 7 October, the same doctor recorded that the man was complaining of pain in his right hip. A bone scan had been carried out but the results were not yet available. He wrote that he would discuss the diagnosis with him on receipt of the results, which he did on 16 October. The bone scan indicated a further metastasis on the man's left thigh bone and one on his ribs. The doctor referred the man for an urgent x-ray of his right hip and pelvis. (The x-ray was performed on 20 October.)

49. At 3.34am on 20 October, the nurse was called to the man's cell. He said his pain was not controlled by the medication so day staff were instructed to liaise with the doctor to arrange for the dose to be increased. Later that day, a doctor prescribed morphine.

50. A charge nurse was called to see the man on 22 October. The man complained of constant pain in his left hip, leg and in his back. He said he had taken his prescribed morphine, which temporarily relieved the pain but was "at the end of his tether". The charge nurse recorded that the man needed to be assessed by the doctor the following day. In fact, the following day, the man was assessed by a nurse. He said he was feeling better and did not need to see the doctor.

51. On 25 October, at 2.15am, the man requested pain relief. The nurse who assessed him noted he had swollen ankles and feet and told him to raise his legs. An instruction was left for the doctor to examine the man and consider prescribing a diuretic (which helps to eliminate excess fluid from the body). There is no record of him being examined by a doctor or being prescribed further medication as suggested by the nurse.

52. Two days later, he moved to a cell that was closer to the servery and the staff office. He was using crutches to walk due to the pain in his hips and as both his feet were swollen. A senior officer (SO), one of the wing managers, raised concerns about whether the man could continue to stay on the wing. However, nursing staff noted that he did not want to be admitted to inpatients. Healthcare staff agreed to visit the man on the wing rather than expect him to walk to the treatment room.

53. The man went to a hospital appointment on 29 October when he was told that the pain in his hip was due to another metastasis. Hospital staff recommended he receive another dose of radiotherapy and that his pain relief medication be changed. On his return to the prison following the radiotherapy, he complained that he found it uncomfortable to travel by taxi. Staff suggested that the man should be provided with a wheelchair and travel in a wheelchair accessible taxi, which would be more comfortable.

54. The doctor the man saw on his first day in prison recorded that the man was experiencing pain in both hips and was taking about 70ml of morphine each day. The doctor suggested that the man be prescribed fentanyl patches (strong pain relief medication).

55. Nursing staff continued to visit the man every day and wing staff were told to contact the duty nurse if they had any concerns. The man was told that he could request a nurse at any time of day or night. His meals were taken to him in his cell and an entry in his prison file notes that he had the "full support of officers and prisoners on the wing".

56. On 2 November, the nurse was called to the man's cell at 10.53pm. The man was in pain and his legs were swollen. Fluid was oozing from his right leg. The nurse bandaged the leg and requested that he be examined by a doctor the following day. The man was examined by a doctor (that had previously seen him on the 20 of October) on 4 November. The doctor requested that the man be taken to the local hospital by ambulance that day.

57. The man remained in hospital until 8 November, where he received doses of radiotherapy. He was admitted to inpatients in the prison healthcare centre. On 16 November, the doctor that he saw on his first day in prison noted that the man was "much more comfortable" and was "managing better in the supportive environment [of the healthcare centre]". He believed it was in the man's interests to remain in healthcare. A pressure relieving mattress was supplied to avoid developing bedsores.

58. Four days later, during the afternoon on 20 November, the man fell in his cell. He complained of pain in his right hip and was taken to the Accident and Emergency department at the local hospital by ambulance. Hospital staff confirmed that the man had fractured his right thigh bone and had a wound on his right foot. They suggested he undergo surgery to place a pin in his right leg. This operation was carried out on 23 November. The man remained in hospital until 27 November, where he received physiotherapy.

59. On his return to the prison healthcare centre, the prison physiotherapist assessed him. The doctor that he had seen on his first day in prison noted that the man was now having trouble finding the right words when speaking (called dysphasia) which was a new development. The man was described as looking frail, although he said he felt well cared for and had no complaints. The doctor recorded that the man should be transferred to a hospice when he reached the end of his life.

60. On 2 December, the same doctor wrote that the man was anxious about his symptoms worsening, and of dying. A Jehovah's Witness elder had visited him. The man was suffering bouts of shortness of breath, possibly due to his anxiety, and was coughing more. He denied being in pain or feeling depressed. The doctor noted that the man had to decide whether he was ready to go to a hospice. The doctor said that his family could visit more often if they wanted to. The man's son was told that, as long as family members gave the prison two to three hours notice, they could visit at any time. His son was given the healthcare centre senior officer's and the doctor's direct telephone numbers.

61. Early the following day, the man pressed his cell bell as he was unable to move to his bed without assistance. He said he thought he should go to the hospice. As a result, the doctor spoke to the Macmillan nurse at the local hospice about the man transferring there. He agreed to liaise with the Governor to see if the man was suitable for release on temporary licence (ROTL) to a hospice. (In certain circumstances, prisoners can be released from prison. Before a decision can be made, a number of risk assessments must be completed. The assessments consider, amongst other things, the risk the individual poses to members of the public and whether they are likely to reoffend.) The doctor also checked that the man still did not want to be resuscitated should his heart stop beating.

62. The application for ROTL was begun on 4 December. The paperwork noted that the man's life expectancy was short and he would be more appropriately cared for in a hospice. The doctor he saw on his first day contributed to the application, he wrote that the man was unable to move without assistance and was unlikely to live for more than three or four weeks. The ROTL application was agreed by the Governor on the basis that the man would move to the hospice when medical staff deemed it necessary.

63. Over the next week, the man complained of continuing pain in his left hip and a swelling on his ribs, which were likely to be caused by further metastases. Staff found him to be "increasingly lethargic, withdrawn and weak". The SO from the healthcare centre contacted the local hospice to find out if they had space for the man.

64. On 16 December, a member of staff from the hospice assessed the man on the healthcare centre. He was "frail and tired" but denied being in any pain. The same doctor that last saw him noted that the man wanted to move to the hospice "to die" and recorded that he did not expect him to live for more than a week or two more. The following day, the doctor met the man's son and daughter-in-law. They were given the chance to ask questions but appeared content with their father's treatment.

65. At 1.48am on 18 December, the man called for a nurse because he was having a spasm in his right arm. Following the spasm, he was not able to grip or use his arm properly. At 10.00am that day, the doctor noted that the man had had two convulsions and continued to struggle to find the right words. The doctor thought it likely that the man's cancer had spread to his brain. He decided that the man should be moved to the hospice that day and that, if no hospice bed was

available, he would need to be admitted to hospital. At 4.30pm, the man was released on temporary licence to a local hospice. He was not to be handcuffed or restrained in any way, and one officer was to be present with him at the hospice. The ROTL was arranged to last until 24 December, when the situation would be reassessed.

66. A doctor at the hospice examined the man that evening and recorded that he was "confused" and talked of getting better. He was unable to answer simple questions. The doctor advised that no further treatment was available and that the man would be kept comfortable.

67. The man's family visited him at the hospice over the next few days. Prison staff present noted that the man was unable to move without help and, at times, was unable to hold a conversation. However, by 22 December, hospice staff recorded that his movement and appetite had improved. Medical staff decided the man would stay at the hospice while they assessed his condition. That night, they saw a "marked deterioration" in the man's condition. However, by 11.00am he had eaten breakfast and was "in good spirits", talking about the "bad night" he had had.

68. At 11.40am, one of the hospice doctors visited the man and told him that as he had suffered no fits and his condition had not deteriorated, he could return to the prison. He went back at 11.00am the following day, 24 December.

69. Over the next few days, the man slept during the day and by 30 December was not eating or drinking very much and appeared "low in mood". However his condition was stable until 5 January 2010. During an assessment at 11.38am that day, healthcare staff recorded that he had not passed urine for 48 hours and was confused (although he did not complain of any further pain). A catheter was inserted.

70. Just over two hours later, staff noted that the man appeared increasingly agitated, confused and disorientated. He had not eaten or drunk anything and was "crying out for help". The hospice staff were contacted and they agreed the man could return straightaway. A non-emergency ambulance arrived at 2.15pm to take the man to the hospice. His family were contacted and told of his move.

71. The man was released on temporary licence to the hospice later that day. At 4.35pm on 6 January, he passed away.

72. The post mortem report confirmed that the man died of widespread cancer, originating in the lung. Other conditions that were mentioned as significant, but not the primary causes of death, were high blood pressure and ischaemic heart disease.

ISSUES

73. The clinical reviewer considered the clinical care provided to the man at HMP Leeds, and specifically, whether the care he received was equitable to that he could have expected in the community. He made four recommendations, three of which I endorse and include in this report.

74. When the man arrived at HMP Leeds, he told healthcare staff he had a number of existing health problems, including high blood pressure, heart disease and kidney problems. The clinical reviewer concludes that the "quality of care for these long term conditions was of a high standard". The man's blood pressure and kidney function were regularly checked by prison healthcare staff. In addition, the man's appointments with hospital specialists were facilitated on a regular basis.

Diagnosis and treatment of the man's cancer

75. In January 2009, the man complained of coughing up brown phlegm. He was examined by a prison doctor who diagnosed a respiratory infection and prescribed antibiotics. The medication appeared to resolve the man's chest condition. He continued to attend blood pressure reviews but did not complain of any further chest problems until mid-March.

76. On 19 March, the man again complained of a "productive" cough (when sputum or phlegm is coughed up). He was assessed by a nurse who asked the doctor to prescribe a further course of antibiotics. A doctor did so the same day, apparently without examining the man himself. The clinical reviewer notes that the prescribing of antibiotics was a "reasonable approach to a presumed chest infection". However, he considers that the lack of direct contact with the patient to confirm the symptoms, perform a clinical examination and agree a treatment plan and follow up appointment is not good practice.

77. The clinical reviewer also notes that the decision to prescribe antibiotics was led by the nurse. He considers that this is only reasonable when the nurse has been fully trained in the management of minor illnesses and is a qualified non-medical prescriber. Healthcare staff at Leeds confirmed that the nurse in question did not have such qualifications.

    The Head of Healthcare should ensure that protocols for the treatment of minor illness are reviewed so that the lines of accountability and governance for both medical and nursing staff are clear.

78. Twelve days later, on 31 March, the man complained of chest pains and was assessed by a different nurse. He told the nurse his sputum was now blood stained (haemoptysis). The clinical reviewer concludes that this "new and important" symptom of haemoptysis should have prompted an urgent review by a doctor. Instead, the nurse asked the man to provide a sputum sample, the tests of which indicated there was no ongoing infection. A week later, a doctor carried out a chest examination and noted the man was wheezing. As a result, the doctor requested a chest x-ray.

The Head of Healthcare should ensure that there are up to date guidelines available to all healthcare staff for the management of urgent symptoms, such as haemoptysis.

79. According to the National Institute for Clinical Evidence (NICE) guidelines, continuing symptoms (usually three to four weeks) or haemoptysis should lead to an urgent chest x-ray request. However, the doctor that saw him on the 12 January made only a routine request for the man to undergo an x-ray. The clinical reviewer explains that patients in the community in Leeds are usually able to arrange even routine x-rays within a few days of referral. The man attended his x-ray appointment two weeks after referral. The clinical reviewer concludes that the appointment should have been arranged for within one week of the doctor's referral.

The Head of Healthcare should ensure that NICE guidelines are readily accessible and routinely used by all clinical staff.

80. The results of the chest x-ray (carried out on 22 April) indicated the man might be suffering with lung cancer. Healthcare staff at Leeds were informed within 24 hours and an immediate cancer referral was completed and faxed to the hospital. The man attended an urgent appointment with a respiratory consultant on 6 May. The clinical reviewer notes that this part of the process went well and is an example of good practice.

81. After the initial diagnosis, the man underwent several urgent investigations, which allowed the formal diagnosis of lung cancer to be made. The hospital consultant had suggested that the man undergo a PET scan to determine whether the cancer was operable, or had spread. Partly because the man, an Irish national, did not have an NHS number, the PET scan could not be arranged.

82. This is a national issue, potentially affecting all foreign national prisoners in prisons in England and Wales. The clinical reviewer notes that foreign national prisoners are not routinely or ordinarily allocated NHS or National Insurance numbers. As in the man's case, this may impact upon the NHS treatment they are able to receive. The hospital respiratory consultant wrote a letter to HMP Leeds on 4 June, in which he said he was:

> " … very disturbed by the medical management that we have been able to offer the man as it falls short of that which would be offered to an individual who was not a prisoner."

However, it is not clear whether the man would have been able to undergo the PET scan had he been living in the community. As an Irish national he would not have needed an NHS number in order to access NHS treatment under a reciprocal agreement between European Union nations. It appears that the company providing PET scans to patients in Leeds was particularly insistent that NHS numbers be provided.

83. Instead of undergoing the PET scan, a number of alternative tests were organised and were due to take place when the man suffered a significant episode of haemoptysis. A CT scan carried out while he was in hospital confirmed that the cancer had spread and was inoperable. The clinical reviewer concludes that, even if the PET scan had been carried out in late May or early June, the outcome would very likely have been the same.

84. At this stage, the man was told he might have only months to live. Medical staff discussed whether he wanted to be resuscitated in the event that his heart stopped. The clinical reviewer notes that the discussions, and the man's wishes, were well recorded both in communications from the hospital and in the man's prison medical records.

85. The clinical reviewer concludes that, overall, the man received "excellent and high quality care" by the hospital and prison following the diagnosis. He notes the involvement of appropriate multi-disciplinary teams, as is now common place in the treatment of cancer. This included Macmillan nurses providing palliative care advice in the prison.

86. Over the coming weeks and months, the man suffered several complications, including metastases in his bones. I am pleased to endorse the clinical reviewer' finding that these were dealt with in a "timely manner" and the care given by prison healthcare staff was "of a high and sometimes excellent standard" and always respectful of the man's wishes.

The man's move to and return from the local hospice

87. In line with the man's wishes, when his condition deteriorated on 18 December 2009, he was transferred to the local hospice. I am pleased to find that the prison quickly agreed the application for ROTL and the man spent his time at the hospice without any handcuffs and with only one accompanying officer. Whilst at the hospice, the man's condition deteriorated but then improved significantly, such that the hospice team no longer considered his death to be imminent. As a result, the man was returned to Leeds on 24 December.

88. Following his death, prison healthcare staff queried the hospice's decision to discharge him back to prison. The clinical reviewer explains that it is not uncommon for patients in a similar condition in the community to return home from a hospice. Furthermore, he notes that the man spent another 12 days in prison. Although frail, his condition was stable before deteriorating again and he returned to the hospice just over 24 hours before his death. Nevertheless, it is disappointing that, especially on Christmas Eve, the hospice decided he should go back to prison.

Contact and support for the man's family

89. It is clear from the records that, once the man had informed his family of his diagnosis, healthcare and discipline staff made sure they were involved in his care. They were informed about the man's treatment and condition and, at the appropriate time, were offered the opportunity to visit him as often as they wished. The fact that the man was twice moved to a hospice afforded them more frequent visits and greater privacy. I am very pleased to find this is the case.

CONCLUSION

90. The man arrived in prison with a history of various health problems, which were well managed by prison healthcare staff. In January 2009, he complained of a cough and was treated with antibiotics, which appeared to have resolved the problem. In April, when he was still suffering with chest problems, he was referred for a chest x-ray which showed he was suffering with lung cancer. Further investigations revealed that it had quickly spread and was inoperable. On 6 January 2010, the man died at the local Hospice in Leeds.

91. The investigation has revealed that once he was diagnosed prison and hospital staff provided the man with a good, and sometimes excellent, standard of care, generally equitable to that he would have received in the community. Three recommendations are made for the Head of Healthcare at Leeds to improve the management of illnesses.

RECOMMENDATIONS

The National Offender Management Service (NOMS) response is recorded in italics beneath each recommendation.

1. The Head of Healthcare should ensure that protocols for the treatment of minor illness are reviewed so that the lines of accountability and governance for both medical and nursing staff are clear.

   Partially accepted. There are care pathways for minor illness. A pathway review will be undertaken to ensure clear lines of accountability.

   Treatment pathways authorised by the Clinical Director contain flowcharts clearly indicating professional accountabilities. All Patient Group Directions give explicit guidance. Staff training emphasises accountability with regards to prescribing and administering practices. A staff training programme is underway with all staff due to complete by December 2010. Two nurses are now trained as non-medical prescribers.

2. The Head of Healthcare should ensure that there are up to date guidelines available to all healthcare staff for the management of urgent symptoms, such as haemoptysis.

   Partially accepted. It is up to individual clinicians to ensure they are up-to-date with all current guidelines and they have to sign to that effect each time they renew their registration. In addition all new guidelines are discussed through the NICE Guidelines group within the NHS where a senior manager attends from NHS Prisons Healthcare.

3. The Head of Healthcare should ensure that NICE guidelines are readily accessible and routinely used by all clinical staff.

   Partially accepted. NICE Guidelines are standing agenda item at the monthly Clinical Team Meeting attended by GP's, Pharmacy and Senior Clinicians and any relevant points are discussed there and relevant action taken.

   The Patient Safety Audit tool is to be reviewed by the end of September 2010. It will be revised to include auditing use of NICE guidelines by relevant staff. The first re-audit is due in October 2010.