

**Investigation into the circumstances surrounding the  
death of a man in November 2011 at hospital,  
whilst in the custody of HMP & YOI Forest Bank**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**May 2012**

This is the report of an investigation into the death of a man. He died in November 2011 at hospital, while in the custody of HMP & YOI Forest Bank. He was 66 years old. He died from cancer of the lung, with secondary contributing factors of emphysema and ischaemic heart disease. I offer my condolences to his wife and family.

The investigation was carried out by one of my investigators. A review of the man's clinical care in custody was carried out by two clinical reviewers on behalf of the local Primary Care Trust. I am grateful to them for their assistance. I would also like to thank the Director and staff of Forest Bank for their co-operation during the course of the investigation.

The man was diagnosed with cancer and began chemotherapy prior to arriving at Forest Bank in June 2011. He continued to attend hospital for treatment after his imprisonment, and was generally cared for appropriately when his health deteriorated following the conclusion of this treatment. No end of life care pathway was used at Forest Bank and, while I do not believe this had a detrimental effect on his treatment, such documents are used in many prisons and have a number of benefits to both the patient and care provider. I recommend to the head of healthcare that an end of life care pathway is used in similar future circumstances.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**May 2012**

## **CONTENTS**

Summary

The investigation process

HMP Forest Bank

Issues

Conclusion

Recommendations

## SUMMARY

1. The man was diagnosed with lung cancer in March 2011, while living in the community. He had begun chemotherapy before arriving at HMP Forest Bank on 10 June. On arrival, his diagnosis was quickly recognised and he was allocated a cell on the healthcare inpatients unit.
2. During his first months at Forest Bank, the man continued to attend hospital for chemotherapy and, in September, daily radiotherapy. His consultant reported that he tolerated the treatment well. However, in the weeks following treatment, he began to experience increasing pain. This was promptly recognised and the clinical reviewer concludes that he was prescribed appropriate pain relief and medication. A local hospice was contacted for advice on a number of occasions and he was visited in prison by a Macmillan nurse.
3. Although he was occasionally inconsistent in his views, it was accepted that he wished to move to hospital when his condition deteriorated. When he became more unwell in mid November, the consultant agreed that he should be admitted. He was taken to hospital in the morning and died the following day.
4. There is no palliative care policy or end of life pathway in operation at Forest Bank. The clinical reviewer comments that this is something that should be urgently addressed, and we recommend to the head of healthcare that such documents should be created and implemented. We also recommend that comprehensive observations are recorded when a man returns to prison following radiotherapy and that earlier contact with the next of kin is established when a prisoner is diagnosed with a terminal illness.

## THE INVESTIGATION PROCESS

5. The investigation was opened on 18 November 2011 when the investigator issued notices announcing the investigation to staff and prisoners and invited those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.
6. The investigator visited Forest Bank on 25 November. During the visit he saw the dormitory in which the man lived in the healthcare centre, and the cell on H wing where he also lived for a brief period. The investigator spoke to the primary care manager, the prison's family liaison officer and staff who knew him on both healthcare and H wing.
7. A review of the man's clinical care in custody was undertaken by two clinical reviewers on behalf of the local Primary Care Trust. The investigator and one clinical investigator visited Forest Bank on 12 December. During the visit they interviewed a prison doctor and the manager of the prison's Offender Management Unit. The clinical reviewer returned to Forest Bank on 22 December and 10 January 2012 to speak with prison nurses. The initial findings of the investigation were fed back in writing to the Director.
8. One of the Ombudsman's family liaison officers spoke to the man's wife, his nominated next of kin, on 13 December, to explain the purpose of the investigation and allow her the opportunity to ask any questions or raise any concerns she might have about the care her husband received in prison. She did not have any issues that she wished to raise at this stage.
9. The man's wife received a copy of the draft report as part of the consultation process. We would like to thank her for considering the report and commenting on its findings. Her questions and comments have been included as appropriate in the report.
10. The report was also sent in draft to the Prison Service. Their response to our recommendations is included on page 16.
11. The investigation assessed the following aspects of the man's care and treatment:
  - Whether he was told about his condition and the treatment which followed?
  - Whether he was treated properly and attended hospital appointments as necessary?
  - Whether the liaison with his family was appropriate?
  - Whether he was accommodated in the most appropriate part of the prison?
  - Whether consideration was given to release from prison?
  - Whether appropriate palliative care was provided?

## HMP FOREST BANK

12. Forest Bank is a local prison located in Salford, holding up to 1,424 prisoners. It accepts remand and sentenced male adults and remand young offenders from courts in the North West. The prison is privately run under contract by Sodexo Justice Services.
13. Primary care services are provided by Sodexo. There is a 20 bed inpatients unit with 24 hour nursing cover. Prison doctors are provided by Cimarron, a GP agency. Doctors are available from 9.00am to 9.00pm seven days a week, with out of hours cover available at other times. There are clinics available for patients with lifelong conditions and an additional clinic for patients who require pain control.
14. HM Chief Inspector of Prisons conducted an unannounced full follow-up inspection in June - July 2010. The Chief Inspector described Forest Bank as a good local prison that had made a number of recent improvements. He reported that healthcare was one of those areas that had improved, with appropriate staffing levels and (unusually) no vacancies. He also reported that cells in the inpatients unit were basic, although there were good relationships between healthcare staff and prisoners.
15. The prison's Independent Monitoring Board (IMB, a body of unpaid local people who independently monitor and report on the prison) report for 2010 commented on the "caring and professional manner" in which staff involved in recent deaths in custody had acted. More broadly, they commented that, overall, there was a lot of "excellent" work done at the prison.
16. This is the seventh death of a prisoner at Forest Bank that the Ombudsman's office has investigated since January 2010. Four of the previous deaths were due to apparent natural causes. The Ombudsman's reports into these deaths found varying levels of care. One investigation found that the prisoner received medical care comparable to what he would have received in the community. However, in other investigations the findings were very critical and found that care, particularly in relation to the provision of medication, was not appropriate.

## **ISSUES**

### **The diagnosis of the man's terminal illness**

17. Around Christmas 2010, the man developed a persistent cough which was followed by breathlessness and fatigue. He was referred for a chest x-ray in March 2011, which showed the presence of a mass in his right lung. A bronchoscopy (using a fibre optic device to see inside the lungs) on 30 March confirmed the presence of a cancerous tumour.
18. The consultant discussed this diagnosis with him, and told him that the cancer was unlikely to be curable. It was planned that he would undertake a course of palliative chemotherapy (treatment to control the symptoms rather than cure the cancer).
19. The man's diagnosis was made before he was remanded into custody. The events leading to his diagnosis are therefore outside of the remit of our investigation. However, the clinical reviewer comments that the diagnosis of his terminal illness was made appropriately.

### **The man's medical appointments and treatment**

20. Hospital notes indicate that the man began chemotherapy at the hospital on 6 May 2011, while still living in the community. He had four sessions before imprisonment, the last of which was on 8 June. The following day, he was taken into police custody in connection with alleged sexual offences committed several years previously. On 10 June, following a court appearance, he was sent to Forest Bank as an unconvicted remand prisoner.
21. Following his imprisonment, he returned to hospital on 17 June, 22 June and 29 June to complete his second cycle of chemotherapy. Entries in his medical record for June and July indicate that he experienced no side effects from the chemotherapy. He attended a hospital clinic on 8 July to review his progress. The consultant oncologist (cancer specialist) reported that he had "tolerated cycle two relatively well", although he had experienced some headaches. It was planned for him to continue with the third cycle of chemotherapy.
22. He subsequently returned to the hospital on 13 July and 20 July to complete his chemotherapy. At a clinic on 5 August to review his progress, the consultant explained to him that he now planned to treat him via radiotherapy. This would involve daily (except weekends) visits to hospital over a period of four weeks.
23. On 17 August and 24 August, the man went to the hospital for preparatory appointments ahead of his treatment. During this time he was reportedly settled and as well as could be expected. Radiotherapy began on 1 September and he attended hospital for a session on every weekday for the remainder of the month. His progress was considered at a clinic on 30 September, where it was noted that he had "tolerated the treatment extremely well".

24. The man received no further treatment other than pain relief and palliative nursing, which is discussed in later sections of the report. He attended a follow up appointment on 11 November. An x-ray taken at this appointment showed that he had “shown a good response” to radiotherapy. However, the x-ray revealed that he had suffered a collapsed vertebrae (damage to the spine). An urgent MRI (magnetic resonance imaging, a scan to provide pictures of the organs and other structures of the body) was requested to determine whether this was related to the cancer. The consultant noted that he would see him again for a review in one week. The man died before this scan or review could take place. The post mortem report comments that his spinal column was “intact” and makes no mention of this injury or its likely origin.
25. Around this time, the man was reluctant to eat and drink and had to be encouraged to do so by healthcare staff. He was given a nutritional supplement and, by 14 November, the doctor decided that intravenous fluids via a drip were required as he now appeared to be slightly dehydrated. The doctor explained that when he reviewed the man later on 14 November, he thought he had now entered the final stages of his life. Following discussion with the consultant at the hospital, it was arranged for the man to be admitted on 15 November for review. Shortly after his arrival, he moved to the hospital’s critical care unit. His health deteriorated further and he died.
26. The numerous appointments that were made following the man’s arrival at Forest Bank were all kept and there is evidence of ongoing communication between prison healthcare and the hospital. However, during the month that he was undergoing daily radiotherapy, there is little evidence in the notes of healthcare staff discussing his treatment with him or of making appropriate observations. A nurse told the clinical reviewer that checks were made each day when he returned from hospital and observations made, but accepted that these were not always recorded. Indeed, there are periods of up to a week at a time when no entry was made during this important stage of his treatment.

**The Head of Healthcare should ensure that appropriate checks and observations are made and recorded when a patient returns from outside hospital following significant treatment.**

27. The clinical reviewer considered the man’s deterioration in the last few days of his life, and the care he received at Forest Bank. He comments as follows:

“In terminal cancer the sufferer progressively becomes weaker and weaker; he or she sleeps more and appetite for both solids and liquids becomes increasingly reduced. The prison records clearly describe a deterioration in his condition consistent with terminal cancer. In this situation, physicians with expertise in palliative medicine usually keep interventions, other than symptom control, to a minimum. Patients who are dying often will exhibit signs of dehydration because the cancer affects their desire to drink. In hospices this is regarded as part of the natural course of someone dying and intravenous fluids would not usually be given.”

## The man's location

28. The man's diagnosis with lung cancer was noted on his arrival at Forest Bank and he was subsequently allocated a cell on the healthcare inpatients unit. He lived on the unit throughout the remainder of his chemotherapy and when undertaking daily radiotherapy. There were some entries in his notes indicating that he tended to remain in his cell and not mix with the younger prisoners. (The population on the inpatient unit is mainly prisoners with mental rather than physical health needs and most patients were much younger than the man, who was 66 years old.)
29. As noted, the man was reported to have tolerated his radiotherapy well. Following the completion of this treatment, consideration was given to allocating him a cell in the main prison on the vulnerable prisoners unit (VPU, a unit for those who need to be, or request to be, separated from other prisoners for their own safety, often on account of their offence). The man was assessed by a prison doctor, who concluded that he would be able to move to the VPU. The advantages to him of such a move were that it would help him to remain independent and give him the opportunity to mix with other prisoners of his own age. He subsequently moved to the VPU on 4 October.
30. The man was initially allocated a single cell but, the following day, moved into a double cell with another prisoner who was happy to help him. He required this help as he became breathless on minimal exertion and therefore struggled with daily activities such as keeping his cell tidy and collecting meals. Despite this help, he continued to struggle and also began to experience pain in his back. He therefore returned to the inpatients unit on 7 October.
31. Although the man's move to the wing was not a success, on account of the potential benefits for him we think that it was an appropriate trial. It was quickly recognised when he struggled to cope on the wing and he correctly returned to the inpatients unit.
32. In discussion with a nurse on 28 October, the man expressed conflicting views about where he would like to be treated when his health deteriorated. He initially said that he would like to be admitted to the hospital but then said that, were he to receive a sentence of three to four years, he would like to remain in prison. (He was not convicted or sentenced prior to his death.) During an interview with the clinical reviewer, the nurse confirmed that he often gave "mixed messages" when asked about the future. However, her overriding impression was that his preferred place of care was the hospital.
33. A prison doctor also recalled a conversation with the man in which he expressed a desire not to die in prison. During a consultation on 31 October, he reassured him that a move to hospital would be arranged at the appropriate time. As we have noted above, he was admitted to the hospital on 15 November and died soon after.
34. While living on the inpatients unit, the man's door was left open during the day and nursing staff were able to open his cell at night to give him his medication.

He was the sole occupant a large room normally used as a four-bed dormitory. The dormitory had an en-suite toilet, and a walk in shower with seat was available for his use further down the corridor. The clinical reviewer describes the facilities for caring for someone dying at Forest Bank as adequate. We think that this dormitory was the most appropriate place for him to live in the prison. It was also appropriate that a move to the hospital was arranged when he deteriorated, in line with his apparent wishes.

### **Palliative care plans**

35. On 14 June, four days after his arrival at Forest Bank, a referral form was sent to the palliative care nursing team at a hospice. He was accepted onto their caseload.
36. A care plan was written on 24 June to outline the actions healthcare staff should take to monitor him for side effects of his chemotherapy or deterioration in his breathing on account of his cancer.
37. As discussed in the later section on pain relief and medication, the man began to experience increasing pain, shortness of breath and nausea in the month after he completed his radiotherapy. A Macmillan nurse at the hospice was contacted by a nurse on 26 October, who gave advice on appropriate pain relief. The Macmillan nurse visited on 1 November and gave further advice regarding medication. It was noted in his medical record that the Macmillan team would provide a formal care plan advising on appropriate treatment, care and the best place for him to be nursed. However, there is no indication that this document was received at Forest Bank.
38. Nursing staff remained in contact with the Macmillan nurses at the hospice, and additional changes to his medication were made following advice received on 8 November. The following day, a care plan was written by the primary care manager at Forest Bank. This included an instruction that the man's food and fluid intake be monitored, as he had begun to find eating difficult in the previous few weeks (and had subsequently been prescribed a nutritional supplement by a prison doctor).
39. Following discussion with the healthcare night nurse on the evening of 14 November, the prison doctor agreed that the man should have 'do not attempt to resuscitate' status. (This means that staff would not attempt to resuscitate him were his heart to stop beating.) Such an agreement should be discussed with the patient and/or their family and a document of the discussion completed. This did not happen. He explained that the man was not capable of having such a discussion at the time as he was "very weak and drifting in and out". He also explained that he did not think it was in his best interests to be resuscitated as he had reached the end stage of his life.
40. There is no local palliative care policy at Forest Bank, and the man was not managed under the Liverpool Care Pathway or similar end of life care pathway. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be

implemented in prisons. Among the benefits of an end of life pathway are that it helps patients to make choices about how they are cared for and where they wish to die.

41. The man's wife told our family liaison officer that she was unaware of the 'do not attempt to resuscitate order' and would have liked to have been consulted about it. Recognition of the patient's wishes with regard to resuscitation should be considered as part of an end of life pathway. Had an end of life pathway been in place, he and his family might have been able to discuss and agree to the implementation of 'do not attempt to resuscitate' status at an earlier stage. The clinical reviewer comments that the omission of such a care pathway at Forest Bank is something they should "urgently address".

**The Head of Healthcare should ensure that a comprehensive palliative care policy, including an appropriate end of life pathway, is implemented at HMP Forest Bank.**

### **Informing the man about his condition and treatment**

42. The man's diagnosis and treatment options were explained to him by the consultant before he was sent to prison. It is clear from the consultant's notes that he was told that his cancer was unlikely to be curable. Entries made when he arrived at Forest Bank indicate that he was aware of his diagnosis and treatment. The referral to the hospice shortly after his arrival states that he was aware of his prognosis.
43. At a clinic on 5 August, the consultant explained the potential benefits and side effects of his upcoming radiotherapy to him. In addition, he discussed his treatment with prison nurses on return from this clinic.
44. Following the discussion with him on 28 October, outlined in paragraph 32 above, a nurse wrote in his notes that she was unsure whether he had a full understanding of his condition. She later explained to the clinical reviewer that he knew he would not be cured but hoped that his treatment would enable him to have a much longer life. Another nurse told the clinical reviewer that she was concerned around this time that he thought that the radiotherapy would cure his cancer. She explained that one of the reasons why she asked the Macmillan nurse to visit was to help address this misconception. The prison doctor's view at interview was that he was not anxious and had accepted his diagnosis and prognosis.
45. It is apparent that the man was fully informed about his ongoing hospital appointments and treatment. Towards the end of his life some doubts were raised about whether he fully understood his prognosis. However, there is evidence that staff discussed this with him and took steps to help him understand what would happen in the future. The clinical reviewer concludes that he was fully supported while living in the healthcare inpatients unit.

## **The man's pain relief and medication**

46. During his first months at Forest Bank, the man took only paracetamol for pain relief. He confirmed with the prison doctor that he was happy with this painkiller and did not complain of pain during the time he was undergoing chemotherapy and radiotherapy. In addition to paracetamol, he was prescribed medication to counteract the side effects of his treatment, such as nausea.
47. Following the completion of his radiotherapy, he told a healthcare assistant on 8 October that paracetamol was no longer sufficient to control his pain. A review was arranged with a prison doctor the following day, after which he was prescribed codeine (prescribed to treat mild to moderate pain). The doctor also gave him a nebuliser (a machine that, similar to an inhaler, allows medication to be breathed in via a mouthpiece) for his shortness of breath. The type of painkiller was changed again to tramadol (used to relieve severe pain) on 12 October.
48. Over the following two weeks, the man continued to experience pain and changes were made to his medication. This culminated in the introduction of oramorph (a morphine based painkiller for severe pain) on 26 October, for which the advice of a Macmillan nurse was sought over the telephone. Dexamethasone (for the nausea he was experiencing as a side effect of treatment) was added following the Macmillan nurse's visit on 1 November, supplemented by gabapentin (for long lasting pain) a week later.
49. The investigation found that healthcare staff at Forest Bank responded promptly when he complained of increasing pain in October and November 2011. The clinical reviewer takes the view that pain relieving medication was prescribed appropriately and that his symptom control was "at least adequate".

## **Liaison with the man's family**

50. The man received regular visits from his wife during his time at Forest Bank. He saw her in the visits hall and was taken there from healthcare in a wheelchair. There was no formal contact between prison staff and his wife before 15 November. That morning, a member of the chaplaincy team was asked to contact her on account of her husband's deteriorating health. It was agreed that she could visit her husband on the healthcare inpatients unit that afternoon.
51. When he was admitted to hospital later that morning, the chaplain telephoned his wife to update her. She and other family members were able to visit the hospital that afternoon. The following morning, when his health deteriorated further, the chaplain again contacted the family to update them. His wife visited and was with her husband when he died at 12.42pm.
52. The man's wife told our family liaison officer that she was unaware of how ill her husband was, in relation to both his deterioration while in the prison and particularly during his last admission to hospital. She thought that communication between the prison and families should be improved.

53. Good practice would be to appoint a family liaison officer at an earlier stage when a prisoner is diagnosed with a terminal illness. This would be beneficial for the family as they would have a point of contact should they have any concerns about their relative. It would also benefit the prison to have already established a relationship should they need to contact the family in the event of a sudden deterioration. The introduction of an end of life care pathway would help to facilitate earlier contact with a family.

**The Director should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness or when a man with such a diagnosis is received into the prison.**

### **Restraints, security and bedwatch**

54. The Prison Service has a duty to protect the public and hence restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will consider the offences and the risk of further offending, as well as the prisoner's health and mobility.
55. When the man attended hospital in June, July and August for outpatient review appointments, restraints were used and he was handcuffed to an escorting officer. At the time, he was mobile and reported no side effects from his treatment. As such, we consider the decision to use restraints to be appropriate at the time.
56. Restraints were not applied during his chemotherapy and radiotherapy sessions. On his final admission to hospital on 15 November, he was accompanied by two prison custody officers and restraints were again not applied. We consider this to be the right and respectful course of action, given his deterioration at this time.

### **Potential release from prison**

57. Sentenced prisoners who are diagnosed with a terminal illness may apply to be released from prison on compassionate grounds. This can be either temporarily, through a process known as release on temporary licence (ROTL), or permanently, via early release on compassionate grounds. Strict criteria must be met before a sentenced prisoner is eligible for release via either of these methods.
58. Prisoners on remand, such as the man, are not eligible for ROTL or early release on compassionate grounds. They can, however, apply to the court for release to the community on bail. He was refused bail at court on 10 June on account of the seriousness of his alleged offence and the potentially long sentence that a conviction would lead to.
59. He met Forest Bank's bail information officer on 13 June. She explained to him the process by which he could reapply for bail and what his options for release would be.

60. Were he to be granted bail by the court, there are three types of accommodation to which he might potentially be released to. Firstly, he could be released to a Bail Accommodation and Support Services (BASS) hostel. However, these hostels do not take persons who have been charged with or convicted of sex offences, and he was therefore not eligible for a place.
61. He might also have been released to approved premises (formerly known as probation hostels and designed to provide an advanced level of residential support in the community). Staff in the Offender Management Unit at Forest Bank made enquiries with two local approved premises, but were told by these establishments that they did not have the facilities to provide the level of care needed by him. He struggled to self-care during the brief time that he lived on H wing and, as such, it is likely that he would also have struggled in approved premises.
62. Finally, he could have been released to private accommodation, which in his case would have been to his family home. It does not appear that he made a further application for bail. He was scheduled to return to court for trial on 18 November, after his death.

## **CONCLUSION**

63. The man arrived at Forest Bank having been diagnosed with incurable lung cancer. During his time in prison he completed a course of chemotherapy and an intensive course of daily radiotherapy. The investigation found, and the clinical reviewer agrees, that his treatment was generally managed appropriately at Forest Bank. However, it would have been beneficial for both him and the staff who cared for him if an end of life care pathway had been in place. In addition, a family liaison might have been appointed at an earlier stage.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that appropriate checks and observations are made and recorded when a patient returns from outside hospital following significant treatment.

*“Accepted – this is now in place and systems have improved.”*

2. The Head of Healthcare should ensure that a comprehensive palliative care policy, including an appropriate end of life pathway, is implemented at HMP Forest Bank.

*“Accepted – there is now a comprehensive palliative care policy in place.”*

3. The Director should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness or when a man with such a diagnosis is received into the prison.

*“Accepted – this is complete and incorporated into the new palliative care policy.”*