Investigation into the circumstances surrounding the death of a prisoner who died in the Leeds General Infirmary in March 2005

Report by the Prisons and Probation Ombudsman for England and Wales

August 2005

CONTENTS

This is the report of an investigation into the death of a prisoner who died on 11 March 2005 in Leeds General Infirmary. The cause of death was cancer of the lung.

The prisoner had been released on temporary licence from HMP Leeds during the final stages of his illness.

One of my investigators, conducted this investigation. A clinical review into the prisoner's care and treatment was requested from the Leeds (West) Primary Care Trust.

I would like to extend my condolences to the prisoner's family for their loss. I would like to thank the Governor of Leeds, and his staff, for their help and co-operation during this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2005**

Summary

On 11 March 2005, the prisoner died in Leeds General Infirmary, having been released on temporary licence by HMP Leeds on 28 February on compassionate grounds. He was 67 years old.

In March 2003, he was sentenced to four and half years imprisonment for sexual offences and supplying a class 'B' drug. This was not his first time in prison. On sentence, the prisoner was transferred to Leeds and shortly thereafter to HMP Acklington. On entering prison, the prisoner had been diagnosed with chronic pulmonary fibrosis. He also suffered from osteoporosis, for which he was receiving the appropriate monitoring and treatment. However, from June 2004, he started to complain of chest pain as well as suffering from a severe shortage of breath. Hospital investigations did not identify any sinister cause.

Throughout the later stages of 2004, the prisoner continued to experience chest pain and it was noted by staff that there was a continual deterioration in his physical condition, particularly weight loss. His deterioration necessitated 24-hour medical care. On 21 January 2005, the prisoner was therefore transferred to Leeds from Acklington. Whilst at Leeds he was referred for further investigative tests at Leeds General Infirmary. Whilst an inpatient in hospital, the prisoner was subject to a bed watch by prison officers because of the nature of his offences. He was subject to restraints until 18 February. However, at the end of February, Leeds decided that his physical condition and the prognosis for recovery was such that further risk to the public was low. In light of this, the prisoner was released on a temporary licence.

The clinical review concludes that the management of the prisoner's chest pain was appropriate. Between September 2004 and January 2005, a lung cancer developed, but the clinical review concludes that this could not have been detected earlier. He was a former coal miner who smoked very heavily.

I make no recommendations in this report

The investigation process

1. The investigation was opened at Leeds on 15 March 2005 when my investigator contacted Leeds. The Governor and his staff produced the prisoner's core record, his medical record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation.

2. My Family Liaison Officer, contacted the prisoner's family on 26 April, offering them the opportunity to meet with her and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that they would like explored and addressed. The family are concerned that the prisoner was not receiving the appropriate care and attention in prison. There is also concern that the lung cancer was not detected at an earlier stage particularly in light of his physical deterioration.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and the scope of my investigation and to request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist him in his enquiries into the prisoner's death.

4. The Leeds (West) Primary Care Trust were asked to provide a clinical review into the care that was given to the prisoner whilst he was in custody. Because the prisoner had only recently transferred to Leeds from Acklington there has been some delay in obtaining the necessary information from the Northumbria Primary Care Trust in order for the clinical review to be completed.

The prisoner

5. He was born in April 1938, in West Yorkshire. He had a partner for approximately 20 years but the relationship broke down about four years ago. Despite the breakdown, they remained friends. Contact was maintained through letters, telephone calls and visits. The prisoner also had an 18-year-old son from this relationship with whom he also maintained contact.

6. Up until his sentence the prisoner lived in Pontefract, West Yorkshire. For most of his working life he had been a coalminer in the Yorkshire area and had also worked as a security watchman on a building site.

7. This was not his first experience of prison. He had previous convictions dating from 1957 for a variety of offences. In January 2003, he was convicted by Leeds Crown Court for a number of sexual offences. He was also found guilty of supplying a Class 'B' drug. In addition, he failed to appear at court whilst on bail resulting in a warrant for his arrest and he

subsequently received a term of imprisonment for this offence. On 14 March 2003, the prisoner was sentenced to four and a half years imprisonment.

8. On sentence the prisoner went to Leeds prison, but on 26 March 2003 he was transferred to Acklington where he quickly settled into the regime. He did not present any disciplinary problems and was described as a quiet, courteous and polite man. At Acklington, the prisoner took up employment as a cleaning orderly but due to his breathing difficulties had to give this up. He did not attend study groups or make use of the facilities and spent much of his time watching TV in his cell. In light of his good behaviour, the prisoner was given enhanced privileges.

9. The prisoner's parole eligibility date was set for 15 April 2005. He had hoped for parole and understood that this would be dependent upon him securing a place in an Approved Premises in the Leeds area as well as a commitment to address his offending behaviour. During an assessment at Acklington, the prisoner commented that because of his deteriorating health he did not envisage a long life after his release.

10. Because of ailing health, the prisoner was a frequent outpatient at Wansbeck Hospital, Northumberland. Prison records indicate that he attended the hospital 13 times from 4 July 2003 to 8 December 2004 for chest X-rays and blood tests, primarily in relation to his known respiratory condition. On each of these appointments, he was subject to restraints and escorted.

11. In mid July 2004, the prisoner complained of pain in the left side of his chest. The pain was worse on breathing in. Acklington referred him to hospital where he underwent some tests on his heart. Nothing was identified and it was the opinion of the hospital that he had pulmonary fibrosis that was consistent with his chest condition.

12. By 10 September, he was still suffering pain in his chest and on several occasions he almost fainted. On 15 September, in conversation with staff, the prisoner threatened to hang himself because the pain was getting him down. On the advice of the prison doctor he was prescribed codeine and observed.

13. On 16 September, the priaoner looked unwell and complained of dizziness for which he was given oxygen and codeine. He was still complaining of chest pains and was admitted to hospital once again for investigation. The tests indicated that the most likely cause of pain was muscoskeletal chest pain. On 30 September, whilst in the healthcare centre at Acklington, he again complained of chest pains. He was told that this was pleurisy and advised to rest.

14. In early October, the prisoner was still complaining of pains in his chest and the fact that the medication he was on was not strong enough to ease the pain. He also complained that the health care centre was not doing

enough for him, despite being told by health staff that recent hospital tests had not identified anything sinister.

15. On 15 October, a letter from Wansbeck Hospital to the healthcare centre at Acklington about recent tests carried out on him identified inflammation and stiffening of the lung due to unknown causes. As a result, he was given steroids and by 18 October this treatment appeared to be working.

16. However, by 24 October, the prisoner was again asking for more codeine and was disgruntled that the dosage had not been increased. He had also threatened to press his cell bell continuously if he did not receive more codeine. Staff told him that an increased dosage could aggravate his chest condition and that the pain he was experiencing was consistent with his known medical condition.

17. Throughout November and December, he was still complaining of chest pains and was making persistent attempts to obtain a higher dosage of codeine. Health care staff rejected his requests for more codeine. They also noted that the prisoner was suffering from insomnia and anxiety. He requested once again to be seen by an outside hospital. He was described as looking frail, having lost a significant amount of weight.

18. On 29 November, he threatened to hang himself unless he was taken to an outside hospital or given stronger painkillers. The prisoner was not happy with the treatment he was receiving. An emergency appointment was made for him to see the hospital doctor. He had threatened to harm himself because of the pain, and he was duly placed on an open F2052SH, a form to monitor prisoners at risk of suicide or self-harm. His intention to self-harm was taken seriously and he was subject to observation. he was asked if he wanted to confide in a prison 'Listener' but he declined the offer. The prison doctor also saw him and assured him that following a series of tests carried out at Wansbeck Hospital in September, nothing untoward or sinister had been found.

19. Throughout December 2004 and January 2005, the prisoner continued to lose weight and complain of chest pain. By 6 January, it was noted that he had lost approximately half a stone in weight in three weeks. He weighed eight stone. He was skeletal and grey in appearance and looked exhausted. He was encouraged to take liquid supplements, and it is at this time that Acklington considered that the prisoner would require 24 hour care because of his deteriorating physical condition. Acklington could not provide such care and alternative locations in the prison estate were sought. By 18 January, staff and fellow prisoners at Acklington were concerned that the prisoner was not eating or able to see to his own hygiene needs. It was noted that he had spent a lot of time in his cell and had not changed his clothes. It was becoming more apparent to staff that he required constant care. A senior manager urged that arrangements be made for the prisoner to transfer to another establishment where he could receive such care.

HMP Leeds

20. Leeds is one of the largest local prisons in the country. It has a 24-hour health care centre with a capacity to accommodate up to 55 patients. Patients requiring specialist healthcare are identified promptly and referred to a visiting specialist or the NHS.

21. The healthcare centre at Leeds provides a comprehensive primary care service with a good medical screening for new prisoners. There is provision for secondary care consultation and treatment in a range of specialist and general hospitals in the Leeds area. The relationship between patients and staff is described as good.

22. It should be noted that the prisoner was transferred from Acklington to Leeds on 21 January 2005, and only spent eleven days in Leeds before he was transferred to an outside hospital for investigation and treatment.

HMP Acklington

23. Acklington is a category C prison for convicted adult males, opened in 1972. It is a former RAF station and is the most northerly prison in the country.

24. There are ten residential units of various designs. The prison can accommodate up to 882 prisoners, half of whom are vulnerable prisoners.

25. Acklington does not have a full time medical officer and does not have an inpatient facility. An unannounced inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) was conducted in April 2003. The HMCIP report highlighted some concerns in respect of the needs of older prisoners, and those with health conditions requiring a level of care that could not be provided at Acklington.

26. However, the HMCIP report said that good working relationships had been developed between the establishment and the regional prison health taskforce. A primary care contract had been agreed with the Northumberland Healthcare Trust and the delivery of healthcare is to National Health Service (NHS) standards.

Events leading up to the prisoner's death

27. The prisoner began his sentence with serious health problems. On reception at Acklington he was known to be suffering from chronic pulmonary fibrosis, mainly emphysema, for which he needed inhalers. He was also taking daily medication for the prevention of osteoporosis. He was a heavy smoker and continued to smoke despite his breathing difficulties. Throughout his sentence, he was encouraged to give up smoking by staff.

28. Initially it was hoped to transfer the prisoner closer to his family and tentative enquiries were made with HMP Hull. However, a place could not be found for him. Alternative arrangements were made for him to transfer to Leeds, which has 24-hour medical care.

29. The prisoner was transferred from Acklington to Leeds on 21 January, primarily so that he could receive 24-hour care for his physical condition. His Inmate Medical Record (IMR) was transferred with him to Leeds. A letter from a medical officer at Acklington addressed to the his counterparts at Leeds, said that in the preceding months the prisoner had been complaining of pains around the back of his neck and left side of his chest. These complaints had been investigated whilst he was at Acklington but no sinister underlying cause was detected. Indeed, it was considered that he was suffering from muscoskeletal pain. For this he was treated with suitable analgesics. The letter said that the temptation to treat these symptoms with increasing dosages of codeine was resisted by medical staff at Acklington, because codeine would agitate his respiratory condition. It also said that the prisoner had a previous history of codeine abuse. At this time it was noted that he was looking very frail. He was also experiencing problems with his mobility.

30. The transfer between prisons took place by taxi. Because of his condition the prisoner was not restrained. A uniformed prison officer and a member of the nursing staff escorted him from Acklington to Leeds.

31. On arrival at Leeds, he was taken to the health care centre for an initial health screen and assessment.

32. It was noted that the prisoner was able to speak in full sentences but could only walk very short distances before becoming breathless. He continued to complain of a pain in the left side of his chest. He was fully aware that investigations into the cause of his pain had taken place at Acklington and the Wansbeck Hospital, and that no sinister underlying cause had been detected. The prisoner was initially located in the health care centre at Leeds where he could be observed and treated.

33. By 26 January, he had settled down well at Leeds and it was hoped that he could be discharged onto a residential wing, provided that an appropriate discharge plan was in place. The plan included daily blood

pressure and breathing checks, as well as weekly weight checks. Arrangements were made for him to be moved to a ground floor cell on 'A' wing.

34. However, at 6.45pm on 26 January, health care staff were called to the prisoner's cell because he was suffering from breathlessness and pain in his chest. At 12.50am on 27 January, staff were asked to attend his cell once again as he was still experiencing breathlessness. It was decided to move his mattress onto the floor of his cell to assist with his breathing and comfort.

35. On 29 January, the prisoner was still complaining of pains in his chest and was taking codeine and analgesics for them. He was also being encouraged by staff to take nutritional drinks in order to build up his strength.

36. By 31 January, staff became alarmed at his continued physical deterioration. He was finding it increasingly difficult to move about. It was apparent that he could not cope on the residential wing and it was decided that the prison doctor should see him, with a view to transferring him back to the health care centre. The prison doctor decided that day to refer the prisoner to Leeds General Infirmary for investigations.

37. At Leeds General Infirmary, he was treated with intravenous fluids to keep him hydrated. He was also given supplements to build up his weight. Whilst being treated at hospital, the prisoner was subject to bed watch by uniformed prison officers. He was restrained by escort chain on the basis that, because of his offence, it was perceived that he posed a risk to the community. The system of bed watch supervision continued from 31 January until 28 February. However, in the light of his deteriorating condition the level of risk that he posed was re-assessed by Leeds. From 18 February, he was still subject to observation by prison officers but was not restrained.

38. On 24 February, following tests that included a CT scan and a biopsy, it was discovered that the prisoner had primary pulmonary adenocarcinoma. No active treatment was possible and the prognosis for a recovery was very poor. The prisoner was made aware of this diagnosis and palliative care was suggested. It was proposed that he should receive such care in a hospice close to his family. Unfortunately, he died before arrangements could be made to transfer him to a hospice.

39. At the end of February, in light of his deteriorating health, the prisoner was released on temporary licence (ROTL) on compassionate grounds. At this time he was seriously debilitated although he could still write letters and make telephone calls. These were monitored by the prison under the terms of the licence. His family took the opportunity to visit him whilst he was in hospital.

40. At 6.40am on 11 March, the prisoner died in Leeds General Infirmary. Because he had been released on a temporary licence there was no member of prison staff with him at the time of his death. At 6.45am the hospital told the duty governor of the prisoner's death.

Events after the prisoner's

41. A member of the prison chaplaincy, visited the prisoner's ex-partner at her home address and told her of his death. The family had anticipated his death, although they expressed surprise at the speed of his physical deterioration. The Chaplain continued to maintain contact with the prisoner's family. The family asked him to conduct the funeral. The funeral took place on 29 March. The prison assisted the family in arranging the funeral and provided financial assistance.

42. On 26 April, a Family Liaison Officer from my office, contacted the family. The prisoner's have expressed some concern in regard to the care and treatment afforded to him whilst he was in custody, and in particular why cancer was not detected at an earlier stage.

Clinical review

43. The clinical review undertaken by the Leeds (West) Primary Care Trust concludes that the prisoner had Fibrosing Lung Disease, possibly related to his coal-mining career. He was a heavy smoker. He developed a non-operable lung cancer (not the type normally related to smoking). The management of his chest disease appeared to be appropriate. He complained of chest pain on several occasions. This chest pain was investigated appropriately. As recently as September 2004, he had detailed examinations of his chest that revealed no cancer. Between September 2004 and January 2005, a lung cancer developed which proved inoperable. It is possible that during this period some of his symptoms related to this but again no abnormality was seen on an x-ray of his spine and ribs. The clinical review concludes that his medical care was appropriate and that it was not possible to detect the cancer at an earlier stage.

Findings and conclusions

44. The prisoner entered custody with very serious physical health problems, notably a progressive lung disease. This condition was being monitored and assessed regularly by the healthcare centre at Acklington, with frequent referrals to Wansbeck Hospital for x-rays.

45. Whilst at Acklington, he had complained of pains in the left side of his chest. It was a firmly held opinion of healthcare staff that the prisoner's worsening health was symptomatic of his known medical condition. Investigations at Wansbeck Hospital did not identify any other underlying cause for the pain he was experiencing. Although he requested higher dosages of codeine to quell the pain, this request was refused primarily because such medication could have aggravated the prisoner's respiratory condition.

46. Acklington does not have a facility for inpatients, and was therefore unable to provide the prisoner with 24-hour medical care. On realising that his condition was deteriorating, arrangements were quickly made to provide him with the appropriate care at another establishment that was close to his family. His condition continued to deteriorate, and Leeds correctly referred the prisoner for further investigation at Leeds General Hospital where it was established that he had cancer of the left lung. The disease was extensive and the prognosis poor, so palliative care was the only recourse.

47. The clinical review concludes that, whilst in custody, the prisoner's chest pains were investigated appropriately and that the management of his chest disease was appropriate. Between September 2004 and January 2005, a lung cancer developed that proved inoperable. The clinical review suggests that during this time it was possible that some of the symptoms related to the development of cancer, but that no abnormality was seen on the x-ray of his spine or ribs. It seems that the prisoner's medical care was appropriate and that it was not possible to detect the cancer at an earlier stage.

48. In light of the prisoner's rapidly deteriorating condition, it was decided to release him on temporary licence on compassionate grounds at the end of February. This I hope will reassure the prisoner's family that he was at least afforded some privacy and dignity in the last days of his life.

Recommendations

I make no recommendations in this report.