INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING

THE DEATH OF A MAN AT

HMP WAKEFIELD IN SEPTEMBER 2005

Report by the Prisons and Probation Ombudsman
for England and Wales

September 2006

This is the report of an investigation into the death of a man at HM Prison Wakefield in September 2005. A post mortem examination conducted by a Home Office pathologist, concluded that the man died of carcinomatosis and carcinoma of the colon.

I offer my sincere sympathy and condolences to his family for their sad loss.

The investigation was carried out by two of my colleagues. I also commissioned an independent clinical review of the management of the man's health needs for the period he was at Wakefield. The review, for which I am most grateful, was carried out by three professionals on behalf of the Wakefield West Primary Care Trust.

I would also like to thank the governor and staff at Wakefield for their full and ready co-operation during the investigation.

The clinical review team make five recommendations regarding local practice and procedure at Wakefield (I have made one additional recommendation of my own). They have also drawn attention to the high standard of care received by the man who died and have highlighted five areas of good practice. I concur with their findings. I should also like to add my own commendation to the staff at Wakefield for the kind and respectful way in which they cared for the deceased.

The final version of my report has benefited from comments I received from the Wakefield Hospice that have enabled me to correct previous inaccuracies.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2006**

Contents

Summary

Investigation methodology

HM Prison Wakefield

Events prior to the man’s death

Consideration of issues arising from the investigation

Recommendations and good practice

Summary

The man was convicted of murder and sentenced to life imprisonment in 1996. He transferred to Wakefield in 1997. Towards the end of October 2003, he began to complain of abdominal pain and an inability to open his bowels. On 31 October, when medication prescribed by healthcare staff at Wakefield proved to be ineffective, he was transferred to a local hospital. A cancer of the sigmoid colon was diagnosed, and he underwent surgery to remove a tumour on 2 November.

On 9 December, it was discovered that the cancer had spread to his liver and was inoperable. He subsequently commenced several courses of chemotherapy, the first of which took place on 20 January 2004. These initial cycles were successful, and his condition and prognosis improved.

On 7 January 2004, the man's solicitor applied for his release on compassionate grounds. The application was refused by the Home Office on 8 June as he had failed to meet the full criteria. The solicitor subsequently applied for Judicial Review to contest the decision to refuse his release. On 12 November, this application was also refused. A subsequent appeal to the Court of Appeal failed on 28 January 2005.

After his condition had stabilised for around nine months, a CT scan on 16 September 2004 showed a progression of the cancer in his liver. As a result, his consultant recommended that chemotherapy would no longer be of benefit to him. He therefore had no further cycles. The man's condition remained stable until February 2005 when it was noted that he was becoming weaker. He subsequently moved into the palliative care suite at Wakefield on a permanent basis on 19 March.

A second application for compassionate release on medical grounds was made on 7 April 2005. His deteriorating condition now meant that he fulfilled all the criteria for release, with the exception of that relating to 'adequate arrangements for the prisoner's care and treatment outside prison'. Hospice admission was not deemed to be appropriate by his MacMillan nurse as he was being cared for well in HMP Wakefield's palliative care suite and she did not consider that he had any specialist palliative care needs that would warrant hospice in-patient care.

The man's condition continued to deteriorate throughout the Spring and Summer of 2005. At 2.02am one morning in September, during a routine check of his syringe driver, the man was discovered to be showing no sign of life. The duty doctor was called, and the man was subsequently pronounced dead at 3.08am. The cause of death was recorded as carcinomatosis and carcinoma of the colon.

I make six recommendations and point to a number of examples of good practice.

Investigation methodology

The investigation was opened on 15 September 2005. My investigators met with the deputy governor at Wakefield, the chair of the prison's Independent Monitoring Board, and a member of the local branch committee of the Prison Officers' Association, to explain the nature and scope of the investigation. My investigators toured the prison and familiarised themselves with the healthcare centre in which the man had been located since 19 March 2005.

On the same day, notices announcing the investigation and its terms of reference were issued to staff and prisoners at Wakefield. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigators.

An independent clinical review into his health needs whilst he was in custody at Wakefield was carried out by professionals on behalf of the Wakefield West Primary Care Trust. The review team interviewed a number of healthcare staff who were involved in the man's treatment and palliative care at Wakefield.

My investigators were given access to the man's prison files, including the Medical Record.

On 11 October, one of my family liaison officers wrote to the man's mother to ascertain whether she had any concerns for the investigation to address. His mother told the family liaison officer that she had no concerns and that she thought the care her son had received at Wakefield had been good.

HM Prison Wakefield

Wakefield is a high security prison. At the time of the investigation, Wakefield held up to 580 adult male long term prisoners.

The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending behaviour courses, including FOCUS (anti-drug taking programme), the Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills programme (ETS)

Healthcare is commissioned by the West Wakefield Primary Care Trust. The healthcare centre provides 24 hour cover and has inpatient beds for up to 21 prisoners. The centre also has a Palliative Care Suite, which is an en-suite single room in a converted dormitory. A Specialist Palliative Care Service is provided by Mid Yorkshire Hospitals NHS Trust.

Events prior to the man's death

The man was transferred to Wakefield in January 1997. At the time, he suffered from back pain for which he was taking medication. He had a history of operations on his back.

In July 2000, he complained of frequent urination and thirst. A blood sugar reading was taken and found to be 14.2mmol/L, well above the normal range of 3.5-5.8mmol/L. This reading is also well above the diagnostic threshold for diabetes. Despite this evidence, and a family history of diabetes, no such diagnosis was made at the time.

A further examination was made on 15 January 2002 following a healthcare review at which the man's previous abnormal results were noted. A blood sugar reading was taken and found to be 23.8mmol/L. At the same time, he complained again of frequent urination and thirst. Diabetes mellitus was diagnosed, and appropriate treatment commenced.

In May 2003, he raised a claim for clinical negligence against Wakefield on account of his mis-diagnosis and a delay in referring him to a diabetic consultant following diagnosis. A settlement of £30,500, including costs, was reached in May 2005.

On 29 October 2003, the man complained that he was experiencing abdominal pain and that he had been unable to open his bowels for five days. He also complained of nausea. He was admitted to the healthcare centre for reassessment two days later. In the meantime, he was given a course of Micralax Enema to help him open his bowels.

On 30 October, the man complained that he had vomited overnight and during the day, and that he had a lot of pain in his lower abdomen. The Micralax had proved ineffective as he remained unable to open his bowels.

On 31 October, he felt tenderness in his abdomen. He was still unable to open his bowels and was therefore prescribed a phosphate enema in the morning. At 2.30pm that day, after the enema had proved to be ineffective, he was referred to the Accident and Emergency department at a local hospital. A cancer of the sigmoid colon was diagnosed.

On 2 November, the man underwent surgery to remove a tumour, which resulted in the formation of a colostomy. By 15 November, he had recovered sufficiently to be able to return to the prison.

In the days after his return to Wakefield, he spoke of being sad and fearful for his future following diagnosis. He dreaded the thought of having to undergo chemotherapy. He also experienced regular pain, particularly in his lower abdomen, for which he was initially given paracetamol before starting a course of co-codomol on 21 November.

On 9 December, the man was seen by an oncologist who discovered that the cancer had spread to the liver. This was deemed inoperable. He was offered oral chemotherapy. He was seen on a weekly basis by a palliative nurse, with whom he was able to discuss his fears of chemotherapy. A prognosis by a doctor, on 23 December, gave him just three to six months to live. Following this, on 7 January 2004, his solicitor wrote to the Lifer Review and Recall Section (LRRS) of the Home Office to apply for his release on compassionate grounds.

The man was reviewed by a dietician on 15 December 2003 with regard to the dietary supplements that he was taking as a result of his diabetes. She recommended that he continued to take two litres of full fat milk and a serving of Ensure Plus (a nutritional supplement) per day. This was again reviewed on 9 January 2004, by the dietetic manager at a local hospital, who deemed the man's dietary supplements to be sufficient.

On 20 January, the man commenced a course of chemotherapy at the hospital. Despite having reservations in the weeks leading up to the treatment, he was more cheerful and optimistic immediately after chemotherapy, and was surprised at how well he had coped with the first session. At a review, mistakenly noted by the senior medical officer at Wakefield, as being on 17 January (it is not clear on which date this review did take place), he was noted to have tolerated the first treatment cycle extremely well. At a further review with the palliative care nurse on 30 January, he was recorded as asymptomatic.

A second cycle of chemotherapy commenced on 17 February, after which he was again optimistic and pleased by his progress. His consultant noted that he had experienced a significant reduction in pain since commencing chemotherapy. Further courses commenced on 16 March and 13 April, complemented by palliative care at Wakefield, and the man was again recorded as responding well to the treatment.

The response by him to his first cycles of chemotherapy also had a positive impact on his prognosis. On 15 March, his consultant gave a prognosis of six to twelve months, a view that was repeated by another doctor on 30 March.

On 15 May, the man was placed on disciplinary report after an incident in the healthcare centre in which he brandished a pool cue at staff. He was subsequently placed in segregation from 19 May for a period of 11 days. In the weeks preceding this incident, the man had made a number of informal complaints with regard to his treatment by staff, none of which was substantiated by any evidence when investigated internally. During his time in segregation, he was seen by healthcare staff on a daily basis. He reported no concerns - other than slightly worse pain in his back, legs and feet on 20 May.

On 8 June, his application for release on compassionate grounds was refused by an LRRS caseworker. The reasons for the refusal are discussed in section 6 of this report. Although the application was refused, LRRS asked the governor to monitor the man's situation closely and, if there were a change in

his circumstances, to consider submitting a new application. An application for Judicial Review to contest the decision to refuse release was submitted on 15 June by the man's solicitor.

The man attended the local hospital on 15 June for review following a CT scan. The results showed that he had responded well to chemotherapy. It was therefore decided to continue with the treatment. It was also noted that he was feeling much better and had reduced his intake of painkillers. The consultant therefore prescribed a further four cycles of chemotherapy. He commenced the first of these the following day, and the second on 11 July.

The man was due to attend an outpatient's appointment at the hospital on 24 August in order to commence a further course of chemotherapy. However, he failed to attend the appointment. There is no record of the reason for this omission. The man again failed to attend a clinic on 7 September, and he therefore missed the cycle. He underwent a CT scan on 16 September, the results of which showed a progression (deterioration) of the disease in the liver. His consultant subsequently wrote to Wakefield to express her "extreme disappointment" that they had not facilitated the man's attendance at the previous clinics. She also stated that, whilst she "cannot say that this has been detrimental to his treatment … the fact that he has now shown progression after what was a responsive chemotherapy raises the question that if he had had his chemotherapy on time would he have continued to have benefit from it?"

As a result of the progression, the doctor recommended that he had no further courses of chemotherapy. He was reviewed regularly in the following months by his Macmillan nurse who wrote to his consultant on 17 January 2005 to say that the man's condition had remained stable following the termination of his chemotherapy.

On 12 November 2004, his application for Judicial Review was refused. His solicitor successfully sought permission to appeal against this decision. The appeal was heard at the Court of Appeal on 28 January 2005 and was dismissed.

On 1 February, it was noted that the man was now weaker and was "beginning to fail". He was also experiencing nausea and pain in his right lower abdomen. On 5 February, the man reported to the healthcare centre with these symptoms, having vomited five times overnight. He was advised to put himself down for sick parade, and he subsequently returned to his cell. There is no record of him having seen a doctor on this occasion.

The man then collapsed on the wing on the morning of 9 February. He was seen by a healthcare officer and complained of pain in the abdomen and an inability to keep down his food. The healthcare officer subsequently arranged for him to be seen by a doctor in the afternoon for further assessment. When he saw the doctor that afternoon, the man reported that he had been vomiting on and off for the last six weeks and that his bowels had not been opening

properly. The doctor recorded that if the pain increased he should be admitted to hospital.

The next day, 10 February, the man reported an increase in pain and that he was still vomiting. The doctor therefore instructed that he be admitted to A+E, and he was subsequently taken by ambulance to the local hospital. The man was admitted as an inpatient and remained at the hospital until 19 February when he was discharged back to the prison.

On his return to Wakefield, he declined admission to the healthcare centre on a number of occasions. However, on 19 March, he consented to admission after his condition had deteriorated quickly, and was given a room within the palliative care suite. He had become increasingly frail and was beginning to experience some confusion regarding his surroundings. On 22 March, he made it clear to nursing staff and to the prison's medical officer, that he did not wish to be resuscitated. The appropriate forms were therefore completed.

Following his admission to the palliative care suite, the man was visited regularly by his mother. No restrictions were made on the number of visits she could make, and she did not have to go through the formal procedures of booking a visit. His mother was also allowed to stay with her son for as long as she wanted on each visit.

On 7 April, a second application for compassionate release on medical grounds was received by LRRS. However, a decision with regard to release was never made in response to this application, as the criteria referring to "adequate arrangements for the prisoner's care and treatment outside prison" were not fulfilled. His case was discussed by a local hospice on 18 May, at a weekly multi disciplinary meeting held between themselves, the local hospital and the community specialist palliative care teams. At the meeting his MacMillan nurse, said that he had no specialist palliative care needs that would warrant a hospice in-patient bed. This was confirmed in a follow-up conversation between the director of Patient Services at the hospice, and the prison's medical officer.

Following his admission to the healthcare centre, the man's condition improved a little. However, he was continuing to experience pain, nausea and confusion, and was becoming increasingly weak. Moreover, in a letter dated 25 April, his consultant stated her belief that the man was approaching the terminal phase of his illness and that his life expectancy could now be measured in days and weeks.

The man continued to deteriorate slowly over the following three months, becoming frailer and weaker as time went on. At times, he also had difficulty sleeping as he was frightened at the prospect of dying while he was asleep. Despite this, his mood remained reasonably positive. He often engaged in conversation with other prisoners in the healthcare centre. On 14 July, the man experienced a two-minute long seizure after falling to the floor when attempting to get out of bed. He had recovered within 10 minutes, but had no recollection of the event and suffered bruising to his right temple and cheek.

He was subsequently given diamorphine for his pain and reported no further discomfort that day.

The man experienced a second fall on 17 July, this time without suffering any injuries. His condition was now beginning to deteriorate more significantly. He had difficulty breathing on occasions and was becoming increasingly weak and frail. By 29 August, he was in considerable general pain. It was therefore arranged for a syringe driver (a plastic syringe that delivers small amounts of a drug continuously through a battery operated pump) to be provided so that more effective pain relief could be offered to him. This commenced on 7 September. As a result, he remained settled and comfortable for a while.

A few days later, shortly after 2.00am, during a routine check of his syringe driver, the healthcare officer found that the man was showing no signs of life. The HCO contacted the duty doctor and telephoned for an ambulance. The man was pronounced dead at 3.08 am. The cause of death was recorded as carcinomatosis and carcinoma of the colon.

At 3.30am, his mother was telephoned by the duty governor, and the news of his death was broken to her. His mother had been expecting to hear of her son's death for several days, and the duty governor telephoned so that the news could be passed on as quickly as possible. She had written to the governor in July 2005 to ask that news of her son's death did not appear in any newspapers when it occurred. This request was passed onto the Press Office on the morning of his death.

Consideration of issues arising from the investigation

Quality of healthcare provided at HMP Wakefield

The clinical review, conducted by Wakefield West Primary Care Trust, comments that the man was very well cared for by a dedicated and professional team. The review found no significant failings or inadequacies in the man's healthcare and clinical management. The review team commended the good quality of palliative care and effective team working. They also identified five areas of good practice, each of which I endorse.

The clinical review also comments on the use of the Medical Record as a communications device at Wakefield, and notes that nursing assessments and plans were generally adequate and accurately recorded. It argues, however, that the Medical Record was overused as a means of clinical communication rather than as a device for recording significant clinical events. The review also comments that some of the clinical entries are illegible, that clinical records were not filed in date order and that they lacked a clear structure.

Healthcare staff should develop a more effective and rigorous means to communicate clinical team decision-making within the nursing process, rather than using the medical record as the main channel for communicating clinical events. Also, the clinical director should seek to undertake an audit of clinical record keeping.

The clinical review also considers the advice given at the man's review on 30 August 2005, when it was recommended that a syringe driver be considered for his pain relief. The syringe driver was, however, not commenced until 7 September. The review notes that this delay was caused by confusion as to the appropriate route by which the device could be obtained.

A procedure for accessing syringe drivers in HMP Wakefield should be developed in collaboration with Wakefield West Primary Care Trust.

Healthcare staff should ensure the consistent and effective use of an evidence-based pain assessment/scoring tool for the care of those with palliative care needs and other patients with pain control needs.

The clinical review also comments on the standard of some of the nursing notes at Wakefield. For instance, the nursing assessment completed on 15 November 2003 is noted by the review team to be partially completed to a reasonable standard. However, the review notes that there is a "focus on retrospective recording of clinical events rather than a proactive approach to the nursing process". The review also specifically identifies sparse management plans entered into the man's Medical Record on 16 June 2004.

Healthcare nursing staff should seek to develop and improve their practice and understanding of the nursing process, specifically the nursing assessment, care planning and review, and evaluation of

nursing care, and how this process is recorded in the nursing documentation.

The review team also considered the décor and environment of the healthcare centre at Wakefield, in particular the inpatients area and palliative care suite, to be of a poor standard.

The décor and general environment of the Healthcare Centre, particularly the inpatients area and palliative care suite, should be improved.

The man's missed hospital appointment on 24 August 2004

The man was due to attend an outpatient's appointment at a local hospital on 24 August 2004 in order to commence a course of chemotherapy. However, he failed to attend the appointment and was therefore unable to take the course. There is no record in his Medical Record of the reason why he failed to attend the appointment.

A specialist registrar in oncology at a hospital in Yorkshire wrote to the doctor at Wakefield on 5 August, following a consultation with the man on 3 August. The registrar clearly confirmed at the end of the letter that the man's next appointment was for 24 August. There is, however, no record in the healthcare centre diary at Wakefield to indicate that an appointment was booked for this date.

The healthcare manager should review procedures for recording future outpatient appointments and reasons for failure to attend scheduled appointments

The man's application for compassionate release on medical grounds

On 7 January 2004, the man's solicitor wrote to the Lifer Review and Recall Section (LRRS) of the Home Office to apply for his release on compassionate grounds. The Lifer Casework Manual sets out the following criteria for compassionate release on medical grounds for those prisoners serving a life sentence:

- the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits on life expectancy, three months may be considered an appropriate period for an application to be made to LRRS), or the lifer is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and

- the risk of re-offending (particularly of a sexual or violent nature) is minimal; and

- further imprisonment would reduce the prisoner's life expectancy; and

- there are adequate arrangements for the prisoner's care and treatment outside prison; <u>and</u>

- early release will bring some benefit to the prisoner or his/her family.

The man's application was refused on 8 June 2004 by an LRRS caseworker as it failed to meet a number of the criteria set out above. In particular, the man's medical reports showed that it was difficult to reach a consensus on his life expectancy, with estimates of up to 12 months in March 2004. There were no arrangements in place for him to take a hospice place on release, and there was no suggestion that his treatment in prison was any worse than that available in the community. There were indications that the man presented a risk of re-offending, because of his failure to address aspects of his offending behaviour. Although the application was refused, LRRS asked the governor to monitor the man's situation closely and, if there were a change in his circumstances, to consider submitting a new application.

On 15 June, the man's solicitor submitted an application for Judicial Review to contest the decision to refuse release. The grounds submitted were that the man's illness entitled him to release, and that the failure of LRRS to refer the case to the Parole Board amounted to a breach of Article 3 (the right not to be subjected to torture or to inhuman or degrading treatment or punishment) of the European Convention for Human Rights. This application was refused on 12 November 2004 by a Justice who found that detailed consideration had been given to the case. The Justice also found that there had been no breach of Article 3, as there was no obligation to refer such a case to the Parole Board if it had been decided that the prisoner was not fit for release.

The man's solicitor successfully sought permission to appeal against the decision to refuse this application. The appeal was heard at the Court of Appeal on 28 January 2005 and was dismissed. The Court again found that there was no breach of Article 3.

On 7 April 2005, a second application for compassionate release on medical grounds was received by LRRS. This application was supported by the governor who judged the man as unable to sustain any concerted attempt at violence and as presenting a low risk of re-offending. However, the governor expressed reservations as to whether appropriate accommodation could be found for the man.

A decision with regard to release was never made in response to the man's second application. As a result of his deteriorating condition, he now met all of the criteria for compassionate release with the exception that there were no adequate arrangements in place for his care and treatment in the community. The prison had held discussions with a local hospice with regard to admitting him. However his MacMillan nurse was of the opinion that the man had no specialist palliative care needs that would warrant hospice in-patient treatment. This view was shared by the prison's medical officer who confirmed that, with the support of his MacMillan nurse, the man was being

managed well in the healthcare centre at Wakefield. A formal referral for his admission to the hospice was not therefore made.

It is clear that, when the man's initial application for compassionate release on medical grounds was received and considered, he did not meet the specified criteria and an appropriate decision was therefore made. The second application was supported by the governor. However, a decision was not reached on this second application as the man did not have the specialist palliative care needs to warrant hospice in-patient treatment necessary. I consider that the palliative care received by the man at Wakefield to be exemplary.

Recommendations and good practice

Recommendations

The governor should consider the following recommendations, of which numbers 1-5 are highlighted in the clinical review:

1. The décor and general environment of the Healthcare Centre, particularly the inpatients area and palliative care suite, should be improved.

2. Healthcare staff should ensure the consistent and effective use of an evidence-based pain assessment/scoring tool for the care of those with palliative care needs and other patients with pain control needs.

3. Healthcare nursing staff should seek to develop and improve their practice and understanding of the nursing process, specifically the nursing assessment, care planning and review, and evaluation of nursing care, and how this process is recorded in the nursing documentation.

4. Healthcare staff should develop a more effective and rigorous means to communicate clinical team decision-making within the nursing process, rather than using the medical record as the main channel for communicating clinical events. Also, the Clinical Director should seek to undertake an audit of clinical record keeping.

5. A procedure for accessing syringe drivers in HMP Wakefield should be developed in collaboration with Wakefield West Primary Care Trust.

6. The healthcare manager should review procedures for recording future outpatients appointments and reasons for failure to attend scheduled appointments.

Good Practice

The Clinical Review highlights the following examples of good practice:

1. Good quality of palliative care nursing and medical care delivered by the prison healthcare team, the local NHS palliative care team and Macmillan nurses, the Consultants in Oncology from local hospitals.

2. Effective and considerate care/custodial management interface within the establishment, in particular the man's effective yet kindly custodial care management, especially during the latter part of his life.

3. Ensuring effective pain control was maintained during the man's last few weeks.

4. Ensuring that the man's nutritional needs were effectively met through liaison with an external professional dietician.

5. Ensuring that the man’s mother could spend time with her son at the prison during his last few days.