PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in August 2011 at the Leicester and Rutland Hospice while in the custody of HMP Gartree

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is a report into the death of a man at HMP Gartree in August 2011. The man died from cancer of the stomach, which had spread to his liver. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to conduct a clinical review into the standard of healthcare the man received while in custody at HMP Gartee. I apologise for the delay in issuing this report.

The man was diagnosed with stomach cancer in April 2010. He initially responded positively to treatment, but in July 2011 it was discovered that the cancer had spread to his liver. He was diagnosed as terminally ill. He was moved to a hospice in August and died there eight days later.

We agree with the clinical reviewer that the medical care the man received while at Gartree was equivalent to that he would have received in the community. While it did not affect the outcome for the man it is a concern to note that an important medical appointment was missed due to poor communication between the hospital and the prison. Risk assessments that resulted in restraints being used did not take into account the man's declining physical health and, although there was a problem with contact details, it took too long to notify his family after his death.

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
Prisons and Probation Ombudsman **October 2012**

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1. The man was sentenced to life imprisonment in 2005 with a minimum period to serve of six years before he could be considered for release. He was transferred to Gartree on 20 December 2006, and had a number of medical conditions including asthma, curvature of the spine, long-term mental health problems, epilepsy and chronic indigestion. The clinical reviewer finds that his medical conditions were managed well over the following years, especially his long standing mental health problems.

2. In November 2009, the man collapsed with chest pain. As part of the assessment of his condition, prison doctors asked for blood tests, which showed that the man had low iron in his blood (anaemia). A referral was made to Leicester Royal Infirmary for further tests. As a result of these tests, he was diagnosed with cancer of the stomach in April 2010.

3. The man was treated with chemotherapy initially and, in November 2010, he had an operation to remove his stomach. He initially showed good signs of recovery but, in July 2011, he started to become unwell again. Further tests showed that the cancer had spread to his liver and he was told his condition was terminal. His health continued to decline and he was eventually admitted first to hospital and then to the Leicester and Rutland Hospice in August 2011, where he died.

4. We agree with the findings of the clinical review that the care the man received while at Gartree was equivalent to that he might have expected in the community. However, an important medical appointment was missed because of poor communication. While the man was not restrained at the hospice at the end of his life, the escort risk assessments for hospital visits did not take into account his state of health and its decline. There was no formal record that release on compassionate grounds had been considered, and the man's family were not contacted until ten days after his death.

THE INVESTIGATION PROCESS

5. One of my investigators carried out the investigation and reviewed the man's prison records. The investigator visited Gartree on 8 December 2011 and obtained further records. He also visited the hospice where the man died.

6. Notices about the investigation were issued to staff and prisoners at Gartree asking anyone who had relevant information to contact the investigator. No one came forward.

7. A clincial reviewer was appointed to conduct a review of the clinical care the man received in custody. The clinical reviewer received copies of all relevant medical and prison documentation, on which he based his findings.

8. HM Coroner for Leicester City and South District was informed of the investigation. A copy of the investigation report will be sent to the Coroner.

9. One of the Ombudsman's family liaison officers, wrote to the man's foster sister to ask if she had issues she would like the investigation to cover. No reply was received.

10. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided. We apologise for the late issue of this draft report which, because of staffing difficulties, was one of a number of delayed cases in the office which we are striving to clear.

11. Comments on the draft report were received from the National Offender Management Service. All the recommendations were accepted and further information has been included on page 16.

HMP GARTREE

12. HMP Gartree is a category B prison near Market Harborough that holds up to 677 life sentence prisoners. The prison has no inpatient facility (it closed in 2010) and nurses hold a triage clinic every weekday morning. Leicestershire County and Rutland Primary Care are responsible for delivering primary healthcare services in the prison and mental health services are delivered by Northamptonshire Healthcare NHS Foundation Trust.

Her Majesty's Inspectorate of Prisons

13. The Inspectorate last carried out an announced inspection of Gartree in May 2010 and found the prison much improved from earlier inspections. The inspection occurred at a time when the inpatients unit had just closed and a new outpatient health care clinical centre had yet to open. Inspectors reported that health services were improving, with good support from a proactive PCT and the Governor. Health care was described by the inspectorate as reasonable, with good GP provision.

Independent Monitoring Board (IMB)

14. In the annual report for 2010/11, the IMB described the pressures of delivering healthcare at Gartree under transitional arrangements. The IMB recognised the role of the Governor and his Senior Management Team in bringing improvement to healthcare services over the previous year. Overall, the IMB were satisfied that the healthcare team ran a good service.

Previous deaths in custody

15. The man's death was one of three deaths of prisoners from Gartree in 2011. All of the deaths were through natural causes. In 2012, there have been two deaths in custody, one through natural causes and one self-inflicted. There are no direct similarities between the circumstances of these deaths.

ISSUES

16. The man spent much of his life in prison. In 2005, while serving a seven year sentence, he confessed to the police that he had committed other offences. This resulted in an automatic life sentence under the Powers of the Criminal Courts (Sentencing) Act 2000. The man was required to serve a minimum of six years before he could be considered for release.

17. Until the end of 2009, the man's medical condition was complex, but stable. He had curvature of the spine and asthma. He was a smoker and had been a heavy substance misuser in the past. The man was assessed as having low intelligence and mental health problems, specifically depression and paranoia. All of these conditions and their symptoms were managed with varying interventions, support and medication. He was seen regularly by health professionals, particularly with regard to his mental health problems.

The diagnosis of the man's terminal illness

18. On 25 November 2009, the man told healthcare staff that he was having chest pains. He was examined by Nurse A, who wrote in his medical notes that he had a chesty cough, but no gastric discomfort, no pain when she pressed on his ribs and his vital signs were normal. The nurse referred the man to the doctor for further assessment.

19. The man was seen by prison Dr A the following day, who said that the chest pain was probably muscular. The doctor advised him to seek more help if the pain worsened or if he became short of breath. The doctor also asked for blood tests because he thought the man looked anaemic. The man was seen on 9 December by prison Dr B, who confirmed he had anaemia, started him on iron tablets and referred him for an appointment with a gastroenterologist at the local hospital.

20. On 15 February 2010, the man was examined by a gastroenterology consultant at Leicester Royal Infirmary, who suggested further tests to find out the cause of his anaemia. These tests included a biopsy (a removal of a small sample of tissue) from the man's stomach. The biopsy was carried out on 12 April and showed that the man had cancer of the stomach.

21. The clinical reviewer in his clinical review writes that the man "was referred appropriately for endoscopy when his mild iron deficiency anaemia was discovered. Once he had been referred to a consultant, his hospital visits were facilitated and he was eventually diagnosed in April 2010."

22. In July 2011, the man told healthcare staff that he was tired and aching all over. He was referred for blood tests and on 26 July, Nurse B spoke to the pathology laboratory to get his results. The results showed that his liver was not functioning correctly, and it was agreed that the man should be readmitted to Leicester Royal Infirmary the next day for more tests and a blood transfusion. After further investigation at the hospital, it was confirmed on 1 August, that the cancer had returned and had spread to the man's liver.

23. As soon as the man reported feeling worse he was referred for tests and admitted to hospital, where it was discovered his cancer had recurred. We agree with the clinical reviewer that the man's diagnosis was appropriately managed by the prison.

Informing the man about his condition and treatment

24. On 11 May 2010, a nurse at Leicester Royal Infirmary phoned Gartree's healthcare department to say that she would be meeting the man when he had his computerised tomography scan on 18 May. (A CT scan uses X-ray equipment to create a picture of the inside of the body for diagnosis.) The nurse was told that the prison doctor, Dr A, would tell the man that he had stomach cancer on the morning of his scan. The nurse agreed to follow this up with the man in the afternoon to provide further information if he wanted it.

25. On 18 May, Dr A explained his recent biopsy results to the man and told him that he had cancer. He said he would need to wait for an outpatient appointment before the hospital could decide how his cancer was to be treated. Dr A wrote in the medical notes that the man understood the diagnosis and that he could approach healthcare staff at the prison anytime to discuss it.

26. As a result of the man's CT scan later that day, it was discovered that he had an enlarged lymph node close to his throat. This suggested that his cancer was already quite advanced, but further tests were required before his treatment could be confirmed.

27. The man was seen by the mental health inreach team as part of his ongoing mental health care on 20 May. The man told the Nurse Practitioner about his recent diagnosis and that he had received good support from his friends on the wing. She recorded that he was motivated to receive any treatment offered so that he could become well to see his children.

28. The clinical reviewer comments:

> "The man was kept informed throughout the time his cancer was being diagnosed and treated and he was encouraged to ask questions; he stated repeatedly that he understood what was happening and that he was pleased with this aspect of his care'.

29. The man was informed of his condition by a prison doctor. There is evidence that the prison and the hospital worked together to ensure that the man was supported throughout his diagnosis. The support he was offered was further enhanced by involvement of the mental health team. We are satisfied that the man was appropriately informed of his diagnosis and treatment.

The man's medical appointments and treatment

30. On 20 June 2010, the man collapsed and was taken to Kettering Hospital where he was diagnosed with low sodium levels. This was quickly rectified and he returned to the prison on 22 June.

31. Aside from this emergency admission, the man attended Leicester Royal Infirmary on many occasions for tests, treatment and outpatients' appointments over the following months. He started chemotherapy on 8 July and completed the course in September. He had a total gastrectomy (full removal of his stomach) on 17 November. While in the recovery suite following this operation, he had a heart attack and was placed on a ventilator. The following day, he had recovered sufficiently to be taken off the ventilator. He returned to the prison on 15 December 2010.

32. The man was assessed by the Clinical Team Manager when he got back from prison, who agreed that he could return to his wing. She added him to the "care-on-wing" list and devised a care plan to ensure that he was seen daily by healthcare to change his dressings and to take regular basic observations.

33. When he got back from hospital, the man was given food through a tube inserted into his abdomen, called a jejunostomy. This was removed on 5 January, when the man began to eat normally. After a period of recovery, he was reviewed at Leicester Royal Infirmary on 21 January 2011 and had further appointments there throughout January and February.

34. On 3 February, the man was due to be seen by a consultant at Leicester Royal Infirmary. He did not attend and the consultant contacted the prison to advise them that he was unhappy about the man's missed appointment. The consultant considered that the prison was depriving the man of potentially curative treatment, and that there was a finite period after surgery that this treatment could be successful. He expressed in strong terms that he expected the man to be taken to his next appointment, scheduled for the following week. The man attended his next appointment and started chemotherapy again on 3 March.

35. The acting head of healthcare informed the investigator that no formal request was received for the man to go to hospital on the 3 February. She said that hospital staff told the prison officers who escorted the man to his previous appointment that his next appointment was 3 February, but no written request was made. There is no record of this conversation and there is no record that escort staff passed details of the appointment to healthcare staff. We share the doctor's concern that the man was prevented from receiving essential treatment because of poor communication between the hospital and the prison and make the following recommendation:

    The Head of Healthcare should develop a protocol with local hospitals to ensure that all appointments are communicated effectively.

36. The clinical reviewer finds ”the overall standard of clinical care provided to The man by healthcare staff and the doctors at HMP Gartree to have been very good”. Apart from the missed appointment on 3 February, which appears to have been the result of poor communication by both the hospital and the prison staff, we are satisfied that the man’s medical appointments and treatment were managed well by the prison.

The man’s pain relief and medication

37. The man took tramadol (a strong pain relief medication) regularly for his spinal condition on occasions and medication to manage his mental health conditions throughout his time in custody. When he was first diagnosed with cancer, he did not complain of pain, but continued to take 300mg tramadol daily. He was prescribed Fortisips (a dietary supplement) to increase his calorie intake when he lost his appetite. When his cancer recurred in July 2011, the man complained that he was aching all over. He was quickly readmitted to hospital where his pain was managed by hospital staff.

38. We have found that the man’s pain management was appropriate and in line with practice in the community.

The man’s location

39. When the man returned to the prison on 15 December 2010 following his surgery, healthcare staff set up a “care-on-wing” plan so that he could stay in his own cell. The management of the jejunostomy and dressing changes were facilitated in his cell over the following six months. The man wanted to stay on the wing because he told staff that his friends were a source of support for him.

40. The man was admitted to Leicester Royal Infirmary on 27 July 2011, after concern about blood test results. On 29 July, he returned from Leicester Royal Infirmary and went back to his own cell. On 1 August, he was re-admitted to Leicester Royal Infirmary’s oncology unit for further assessment at which time it was discovered that his condition was terminal.

41. The hospital team decided to transfer the man to the hospice on 12 August. The Nurse Practitioner from the prison’s mental health team visited him on 16 August, and he said that he was more comfortable in the hospice than he had been at the hospital.

42. We are satisfied that healthcare staff took measures to allow the man to stay in his cell for as long as possible, at his request. He was transferred to hospital when his needs could not be met in prison and he moved from there to a hospice where he could be more comfortable. We are satisfied that the man’s location throughout his illness was appropriate to his needs.

Palliative care plans

43. 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 carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. There is no record of a written end of life pathway being completed for the man. However, his condition was not considered to be terminal until after his hospital admission on 1 August when his care became the responsibility of the hospital staff. A place was then arranged for the man in a hospice which provides specialist palliative care for dying patients. We are satisfied that this provided appropriate end of life care for the man.

Restraints, security and bed watch

44. When prisoners are taken to hospital, a risk assessment should be completed which considers the risk posed to the public by the prisoner, their potential for escape and the likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used, if they are needed. The risk assessment should effectively balance security needs with the health and dignity of the prisoner, and be reviewed by prison managers each day that a prisoner is in hospital and amended as necessary. The assessment should include medical opinion about how the prisoner's condition impacts on his risk.

45. From the beginning of 2010 until the time of his death, 34 escort risk assessments were completed for the man. He was assessed as a medium risk to the public, with no risk of escape, and on each occasion he was restrained using double handcuffs apart from a medical emergency in June 2010, when an escort chain was used. (Double handcuffing requires the prisoner to have his wrists handcuffed in front of him and one of his wrists is then attached to an officer by another set of handcuffs. An escort chain is a 1.8 metre length of chain with a handcuff at either end which is attached to an officer and the prisoner.) Healthcare contributions were completed for each risk assessment, but they considered only the following three questions:

- Can the prisoner be double cuffed?
- When at his appointment will restraints need removing/reducing due to examination?
- Does the prisoner know about the appointment?

46. Healthcare staff answered these questions in all risk assessments and signed and dated to confirm that they had no objection to using double cuffs, as long as they did not interfere with treatment. Even when the man had just had his stomach removed and could only eat with a jejunostomy, he was still considered a medium risk and double cuffed. During chemotherapy sessions, his cuffs were removed so that he could receive the drugs intravenously without obstruction, but applied as soon as treatment had finished.

47. In June 2010, a concordat was agreed between the National Offender Management Service and the National Health Service. The concordat makes clear that the medical condition of the prisoner should be considered as part of a risk assessment. The levels of restraint used must be proportionate to the perceived security risks and balanced by considerations of care and decency. The concordat says that "Using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts unless justified by security consideration".

48. We accept that the Prison Service has a duty to protect the public. However, there is also a responsibility to balance the need to hold prisoners securely with the duty to treat them with humanity and to maintain their dignity and privacy. There is no evidence that Gartree considered the man's physical health at the time of each escort, and the effect that would have had on the actual risk he posed. All of the risk assessments came to the same conclusion, and he was restrained throughout his illness despite his deteriorating health.

49. The man's last escort risk assessment on 1 August was originally the same as all of the previous assessments. It noted that he was a medium risk to the public and he needed to be double-cuffed. The senior officer who completed the form then varied the restraints level because the doctor recommended that he was single-cuffed due to his health. It was agreed that an escort chain could be used instead of double cuffs. Once the man had arrived at the hospice on 12 August, escort staff were given permission to remove all forms of restraint.

50. Until that stage none of the escort risk assessments took account of the man's physical health and the actual level of risk he posed to the public. Even when his physical health was taken into consideration on 1 August restraints were still used until 12 August, despite his critical condition. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their healthy and mobility, and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

51. Prison Rule 22 says that "if a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonable have asked should be informed."

52. Throughout the man's illness, he insisted that he did not want his family to be told of his condition. It was not until Saturday 13 August, when the prison chaplain, visited the man at the hospice that he eventually agreed that he would like his brother to be told. A prison's family liaison officer was

appointed. The family liaison officer searched the man's personal effects but could not find his brother's telephone number. Eventually, she found his sister's address in his possessions and wrote to her on 15 August.

53. At the time of the man's death, Prison Service Order (PSO) 2700 governed the management of safer custody in prisons. The PSO required that prisons have clear details of who should be contacted in the event of a prisoner suffering a serious illness or having a serious accident. (This is a mandatory requirement in revised guidance that came into force in April 2012.) No details were held for the man, which led to a delay in his next of kin being contacted.

54. Ten days after the man's death, the prison family liaison officer contacted the police who had spoken to the man's foster mother, and one of her daughters was identified as the man's next of kin. From that point, the prison kept in touch with the man's foster sister and helped to arrange his funeral.

55. We consider the prison should have been more proactive in their attempts to contact the family after his death and ought to have sought contact details from the time that the man's condition was diagnosed as terminal on 1 August. There are no entries on the family liaison log between the man's death and 30 August, so no evidence that any efforts were made to trace his family in that time.

The Governor should ensure that details of next of kin and others to be contacted in an emergency should be held for every prisoner so that they can be informed of a prisoner's serious illness or death as soon as possible.

Compassionate release

56. Prisoners who are suffering from a terminal illness and for whom death is thought likely to occur soon can be released from prison by early release on compassionate grounds. Arrangements for prisoners such as the man who was serving life sentence are set out in PSI 29/2010 which amended PSO 4700 – The Indeterminate Sentence Manual.

57. The investigator spoke with prison managers, A and B about whether the prison had applied for the man to be released on compassionate grounds. Prison manager A explained that senior management at Gartree had considered applying for compassionate release, but were concerned because he had no family contact or home address. He said that the man's illness progressed too fast for the Probation Service to have found him somewhere suitable to live, and senior managers agreed that an application was unlikely to be successful.

58. There was no formal written record of this consideration, and neither was there any record that the man was consulted about it to establish his wishes. We believe it is important that compassionate release is considered for all prisoners with a short time left to live, so that where possible they are able to

have a more dignified death. However, we accept that in the man's case it would have been difficult for him to meet the criteria.

The Governor should ensure that the possibility of compassionate release on medical grounds is considered and documented in all cases where a prisoner is terminally ill.

CONCLUSION

59. The man arrived at Gartree prison on 20 December 2006, with a number of health problems, all of which were well managed by health services at the prison. When staff at Gartree were first made aware that the man had been diagnosed with cancer, they liaised with local palliative care services and followed their guidance. The clinical reviewer considered that the care provided by healthcare staff was of a high standard.

60. There was some poor communication between the hospital and the prison which resulted in the man missing one important medical appointment, but otherwise his treatment was satisfactory. The man's declining health and physical condition were not taken into account when the prison completed escort risk assessments and we consider the level of security restraint used was not justified. Consideration of the possibility of release on compassionate grounds was not documented. The prison had no emergency contact records for the man which resulted in too long a delay in contacting the man's next of kin after his death.

RECOMMENDATIONS

1. The Head of Healthcare should develop a protocol with local hospitals to ensure that all appointments are communicated effectively.

   Accepted: *Protocols with local hospitals have been established including a 10 day follow up on all hospital appointments.*

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their healthy and mobility, and are based on the actual risk the prisoner presents at the time.

   Accepted: *Assessments of risk have been reviewed and will fully take into account individual circumstances, including health and mobility. Health and Mobility factors will also be individually reviewed at each occasion for each individual.*

3. The Governor should ensure that details of next of kin and others to be contacted in an emergency should be held for every prisoner so that they can be informed of a prisoner's serious illness or death as soon as possible.

   Accepted: *NOK details are refreshed on initial reception and subsequently annually to ensure accuracy. They are also reviewed and updated if required during any significant event that may happen in between.*

4. The Governor should ensure that the possibility of compassionate release on medical grounds is considered and documented in all cases where a prisoner is terminally ill.

   Accepted: *Any person identified as being terminally ill will be considered for early release on compassionate grounds. The outcome of this review will be documented on the case notes of the prisoner reporting system.*