PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at hospital in October 2011, while in the custody of HMP Brixton

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is the report of the investigation into the circumstances surrounding the death of a man who died in October 2011, at hospital. He was 59 and in the custody of HMP Brixton when he died. I offer my condolences to his family and friends.

The investigation was conducted by an investigator. In addition, the local Primary Care Trust commissioned a review of the man's clinical care, which was undertaken by two clinical investigators. I apologise that the report has been delayed.

The man arrived on remand at Brixton on 29 April 2011. He had been diagnosed with liver cancer at hospital before his imprisonment. Prison officers subsequently escorted him to outpatient appointments at the hospital. Despite starting chemotherapy his condition declined rapidly. It was recognised that he was terminally ill and a referral was made to the community palliative care team at a nearby hospice.

The clinical reviewers found that Brixton healthcare staff managed the man's condition well in prison, with advice from the palliative care team, until he was admitted to hospital on 2 October, where he received palliative care while waiting for a bed in a hospice. Sadly, his health quickly deteriorated and he died in October.

It is troubling that, because he was an un-convicted prisoner, the man could not be released on temporary licence as might have been the case if he had been sentenced. Moreover, the courts did not agree to release him on bail as he had no suitable address and he died before the matter was reconsidered. Although he died in hospital it is sad that he could not formally be released from his imprisonment before his death. I make no recommendations in this report, but recognise the excellent care given by staff at Brixton who treated him with compassion throughout his illness.

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 **August 2012**

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SUMMARY

1. The man was a 59 year old man who had already been diagnosed with liver cancer when he entered custody. He had been waiting for two years for a liver transplant when he was taken to HMP Brixton on 29 April 2011. He was remanded into custody to await trial for an offence of arson with intent to endanger life. During the reception process, staff recorded his medical history and current medications. They noted that he was receiving treatment at hospital.

2. He was seen by a consultant oncologist at hospital in August. He was told that his prognosis was very poor and that the disease was incurable. He was informed that he was too ill to have a liver transplant and had only a few months left to live. He was given chemotherapy.

3. When he returned to Brixton, he received additional help. Doctors, nursing staff and the prison's Imam all offered their support. Healthcare staff implemented a care plan. A palliative care nurse from a nearby hospice visited and advised staff about pain control. Healthcare staff stayed in contact with the palliative care nurses from hospital.

4. The man was admitted twice to the hospital's accident and emergency department when his condition deteriorated. Brixton prepared an application for his early release from prison on compassionate grounds to prepare for his likely admission to the local hospice. However, there were no beds available in the hospice.

5. His health deteriorated very rapidly and he was admitted to hospital on 2 October, where he was cared for by the liver and palliative care teams. He died in his sleep on shortly after.

6. The post mortem report confirmed that the cause of the man's death was pneumonia and pulmonary oedema (fluid accumulating in the lungs) due to cirrhosis (long term damage) of the liver and cancer of the liver.

THE INVESTIGATION PROCESS

7. The Prisons and Probation Ombudsman (PPO) was notified of the man's death on 7 October 2011. Notices announcing the Ombudsman's investigation were displayed at HMP Brixton to staff and prisoners who were invited to contribute any relevant information. No prisoners or staff made contact with the investigator.

8. The investigator examined all of the documentation relating to the man, including his prison record, clinical record, escort records and bedwatch logs.

9. One of the PPO's family liaison officers contacted one of the man's daughters to discuss the purpose of the investigation and any concerns she had. She wanted to know more about her father's court case and the time he was in prison. She also asked if any consideration was given to releasing her father in view of his illness. We hope that this report helps answer some of her questions.

10. The local PCT commissioned a review of the clinical care the man received at Brixton. A clinical reviewer completed the review.

11. The investigator contacted Her Majesty's Coroner to explain the scope of this investigation. The investigator received a copy of the post mortem report. A copy of our report will be sent to the Coroner to assist enquiries into the man's death.

12. The investigator visited Brixton on 25 October. He visited the man's cell on D wing (the healthcare wing), and spoke with members of staff including the Governor.

13. On 25 January 2012, the investigator returned to Brixton, where he and the clinical reviewers interviewed three doctors and a nurse.

14. 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.

15. We regret the slightly late issue of this report which was caused by the need to wait for the clinical review and a subsequent unexpected staff absence while the report was being completed.

16. As part of the consultation, the man's family received and commented on the draft version of this report. The family were concerned the "do not resuscitate" was used appropriately given he was often confused. His daughter said that a nurse had spoken to her a week before her father died, told her that he was very ill but that he wanted to die alone. She said that she wished she had been told to come over from abroad before he died. The family also said that they had still not received his property. An investigator from this office pursued this with Brixton and established that a parcel had

been sent from Brixton via the courier TNT. However, the parcel seems to have been lost. Brixton are now pursuing this matter with TNT.

HMP BRIXTON

17. HMP Brixton receives male prisoners, both convicted and un-convicted, from magistrates' courts and crown courts in the London area. Brixton holds a maximum of 798 men, mostly in shared cells. The chaplaincy team includes a full-time Imam (Muslim Chaplain).

18. The man lived on D wing, a 26 bed inpatient healthcare centre which deals principally with prisoners who suffer from mental disorders. Healthcare services are commissioned by the local PCT and delivered by a consortium.

Previous deaths at Brixton

19. There have been nineteen previous deaths at Brixton since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004. There are no significant similarities between those previous investigations and the circumstances of the man's death.

Her Majesty's Inspectorate of Prisons

20. HM Chief Inspector of Prisons completed an unannounced full follow-up inspection of HMP Brixton in December 2010. In relation to healthcare, Inspectors reported that prisoners were generally positive about access to health services and their quality. Inspectors found that health services were well managed but the inpatient unit and wing treatment rooms were not fit for purpose. Prisoners received a good GP service. The Inspectorate was critical of the provision for mental health in-patients who waited too long for transfers to hospital. It was noted that the prison had developed palliative care and end of life policies.

Independent Monitoring Board (IMB)

21. Each prison is monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to prisoners and every aspect of the establishment. The most recent annual report published by the IMB at Brixton covers the period from 1 September 2010 to 31 August 2011. In relation to healthcare, the IMB acknowledged the staff commitment across the prison and especially on the healthcare wing. They noted that D wing (the in-patient unit where the man lived) was unfit for purpose but that it was maintained as well as could be expected and that prisoners there valued the decoration on the wing and the garden area.

ISSUES

22. The man was born abroad in 1952. His first language was English. He was married and a devout Muslim. He had a lung removed in 1995, after breaking several ribs in an accident. After experiencing some problems with his liver, he was referred to a consultant in his home country. Due to the nature and severity of his medical condition he could not continue to be treated there. He came to the United Kingdom in 2009 and underwent several months of treatment at a hospital in London. When he was arrested, he had already been diagnosed with liver cancer and had been waiting for a liver transplant for two years.

The diagnosis of the man's terminal illness

23. On 19 April 2011, the man was arrested for an offence of arson with intent to endanger life and taken to a police station in London. He told the police that he had only one lung, suffered from cirrhosis of (damage to) the liver and had liver cancer. He was taking medication which he carried with him. He was intoxicated when he was arrested and stated he had consumed three pints of beer and a glass of wine earlier that afternoon. He was kept under observation and when he experienced stomach pain and breathing difficulties the following day he was sent by ambulance to hospital.

24. He was kept in hospital. Staff noted that he was being treated at another hospital for liver cancer which had spread. (He was supposed to have gone to a check-up appointment but had not attended.) He was diagnosed with chronic blood loss, chronic liver disease and iron deficiency. He was given a blood transfusion and started taking iron tablets. His condition stabilised and he returned to the police station on 27 April.

25. After being formally charged by the police, the man appeared at a magistrates' court on 29 April. He was refused bail because it was thought he was likely to abscond. The court also took into account the severity of the alleged offence and the risk of further offending. He was remanded into custody at HMP Brixton to await his trial at Crown Court.

26. On reception at Brixton, the man was seen by a nurse. The nurse recorded his history of liver cancer and the loss of one of his lungs. She also noted his current medication and wrote in the clinical record that he had recently spent a week in hospital. He told the nurse that he had been waiting for a liver transplant for two years. The nurse referred him to a doctor.

27. A doctor then assessed the man, recorded all of his medical conditions and noted that he was under the care of a hospital. The doctor thought that he appeared stable and was not jaundiced. He arranged a new appointment for him at hospital.

28. On 2, 9 and 24 May, the man received a course of hepatitis B injections. He was seen by doctors on 27 May, following a nose bleed. Regular weekly blood tests were arranged after it was noted that his recent results were

slightly abnormal. A doctor saw him on 4 June, and noted that he looked well and, although pale, was still not jaundiced (jaundice is a yellowing of the skin caused by liver disease). The doctor planned to prescribe him iron tablets, ensure he had high protein meals and arrange a review appointment at hospital after a forthcoming scan.

29. Staff at hospital performed a scan of the man's chest and abdomen on 6 June. The scan showed that his liver was damaged and that his liver cancer had spread. The spread was near his kidneys and measured six centimetres. There was no evidence that the cancer had spread to his lungs. Staff at the hospital planned to begin chemotherapy and offer him a further review with an oncologist.

30. A doctor saw him at Brixton on 5 July. He told the doctor that he had been feeling occasionally light-headed for a couple of months. The doctor noted that he had a cough, but no shortness of breath or chest pain, and diagnosed a chest infection. He prescribed him amoxicillin (an antibiotic). By 15 August, his coughing had stopped and his chest infection much improved. The doctor advised him on the use of his inhaler for asthma.

31. On 18 August, the man attended an appointment with a consultant oncologist at hospital, who informed him that his prognosis was very poor and his cancer was incurable. He was too ill to have a liver transplant and he was told that he only had a few months left to live. The consultant prescribed chemotherapy tablets to take orally as a palliative measure and arranged to see him every three to four weeks.

32. The clinical reviewers reviewed the clinical care offered to the man in prison. They found that he was escorted to all his outpatient appointments to obtain his diagnosis and that healthcare staff at Brixton recognised his terminal diagnosis at an early stage.

Informing the man about his condition and treatment

33. The man knew about his diagnosis before he was remanded into custody. In their clinical review, the reviewers note that he was given support from medical and nursing staff at hospital. They comment that the level of assistance he received was significantly increased when he was told by the consultant oncologist in August that his life expectancy was just months. Brixton's Imam provided him with support.

34. After the consultant gave him a poor prognosis on 18 August, healthcare staff at Brixton increased the level of support for him. They began Assessment Care in Custody and Teamwork (ACCT) monitoring to provide extra support and checks for him because of his frail condition. (The ACCT process is normally reserved for prisoners who are thought to be considering harming themselves or taking their own lives.)

35. Healthcare staff told the investigator that they sometimes use the ACCT document to provide additional care for prisoners like the man. The intention

is to ensure that discipline staff also take responsibility for monitoring the prisoner's general wellbeing and can then alert nursing staff if they have concerns. The ACCT process is used by healthcare staff at Brixton as a way of formalising, ensuring and documenting discipline staff contact with a chronically ill prisoner like him. A nurse stressed that the ACCT process was not used because staff were concerned about him having suicidal thoughts, which he did not. The need for ACCT monitoring was reviewed weekly, but continued until he went to hospital.

36. We recently investigated the death of a man at HMP Pentonville. He had spent time at Brixton, where he had also been subject to ACCT monitoring for the same reason. We commented:

> 'The ACCT procedures were begun to ensure that these observations, in conjunction with the clinical care plan, would be carried out by wing staff. While this is a highly unusual reason for implementing such procedures, it was an imaginative and appropriate way in this instance to ensure that the risk posed to [the man] due to his physical health issues was managed.'

Although once again a highly unusual departure from the normal use of ACCT procedures, on the particular facts of this case we believe the ACCT process was well used to support the man.

37. A nurse also prepared a care plan for him. She added him to the mental health team caseload, encouraged his attendance at education classes and involved a Muslim chaplain in his care.

The man's medical appointments and treatment

38. The man attended all of his outpatient appointments at hospital. He was escorted by prison officers without any delay. Despite taking chemotherapy tablets, his condition declined rapidly. He was kept under regular observation and his physical and mental health was constantly reviewed.

39. At 2.00am on 20 September, a nurse was called to the wing to assess him because his cellmate was concerned about him. He was sitting on a chair, verbally unresponsive and seemed confused. He had tremors in both arms. His blood pressure was very high. Staff called an emergency ambulance and he was taken to hospital.

40. The man underwent tests at hospital and his condition stabilised. By 26 September, he was talking normally without signs of confusion. After being reviewed by the oncology and palliative care teams, he was discharged on 29 September and given an appointment to see the oncology team on 20 October.

41. He was admitted back onto D wing (the hospital wing) at 5.00pm on 29 September. He told the nurse that he was not in pain or in any discomfort. His blood pressure was regularly checked and he was kept under observation

due to the likelihood of his physical health deteriorating quickly and unpredictably.

42. The following morning, 30 September, he again seemed confused and unsteady on his feet. He had difficulty swallowing his medication. His blood pressure was high so the doctor examined him. The doctor noted that he was not in pain but was slightly confused. He decided that the man would be reviewed each day. Staff contacted the hospice to discuss the possibility of transferring him there. The doctor also decided that he should be transferred to hospital as soon as possible if his health suddenly deteriorated.

43. Staff at a hospice explained that they did not at that time have a bed for the man and advised the healthcare team to liaise with the palliative care department at hospital. The same afternoon, 30 September, a doctor and a nurse met him to review his care. He understood that his health was deteriorating and that he was receiving palliative care only. The doctor had a frank discussion with him about his resuscitation arrangements and agreed that resuscitation would neither be successful nor be in his best interests.

44. The man became more confused and disorientated. He slept most of the day. The following day, 1 October, a doctor noted that he appeared a little less confused. The nurses kept regular checks on him. He was helped with personal hygiene, with a change into clean clothes and he had his bed sheets changed. Still confused, he was helped into bed and he slept through the night.

45. On 2 October, the man's condition deteriorated rapidly. He was uncommunicative and unable to either open his eyes or take his prescribed medication. A doctor decided that he needed palliative care. The prison did not have the facilities to provide appropriate end of life care. As there were no beds free at the hospice, the doctor recommended that he be taken to hospital until a hospice bed became available.

46. The doctor told the paramedics about the man's resuscitation wishes. He was taken to hospital, where he was cared for by the liver and palliative care teams. He was still waiting for a transfer to a hospice when he died in his sleep.

The man's medication and pain relief

47. The man was prescribed the following medications:

- Spironolactone, vitamin B compound and thiamine, for his alcoholic liver disease.
- Beclomethasone inhaler and salbutamol for his asthma
- Omeprazole and ferrous sulphate for his anaemia
- Amlodipine for high blood pressure
- Lactulose and phosphate enema for constipation
- Codeine phosphate for pain relief
- Sorafenib (oral chemotherapy)

- Dexamathasone for liver cancer

48. The man brought his own medication to Brixton and was allowed to keep it in his possession. The community palliative care team and the local hospice provided regular advice which was acted upon by healthcare staff at Brixton.

49. As his health deteriorated, he lost weight and complained of tingling sensations in his arms and legs. He did not initially complain of pain. A doctor diagnosed oedema (swelling caused by accumulation of fluid beneath the skin) and prescribed codeine phosphate tablets for pain relief.

50. On 31 August, he was assessed by a palliative care nurse from a hospice. She discussed his case with the healthcare team who continued to seek advice from the community palliative care team and the local hospice about pain relief during the following weeks.

51. When a nurse assessed him on 7 September, she noted that his health was slowly deteriorating. He had a pale yellowish complexion and seemed breathless, his movement seemed slower and he was complaining of pain in his right lower side. The nurse discussed his pain relief.

52. The man's health continued to deteriorate and by 12 September, a nurse thought that he was becoming more confused. She made sure that he knew which medication he should be taking. He produced a large bag of various tablets which indicated that he had been taking his medication irregularly. From this point onwards, staff supervised his daily medication to ensure he took the right amount of each drug.

53. As the clinical reviewers comment, he was a very independent man who preferred to manage his own medication. This decision was fully supported by the nursing staff to begin with. When his condition started to deteriorate and he became confused, the nursing staff helped him to continue to manage his medication independently until it became very clear that he needed more support. The clinical reviewers consider that healthcare staff and the palliative care team managed his pain particularly well, while helping him to maintain some independence.

Liaison with the man's family

54. The man told a nurse that he would like the Muslim chaplain to update his family about his condition. The nurse liaised with the chaplain. After he was sent by ambulance to hospital, the chaplain visited him on 21 September. He then telephoned the man's son aborad to say that his father was very ill and provided the hospital's contact details.

55. When he was discharged from hospital at the end of September, the chaplain told the man's daughter that her father was back in the prison healthcare centre. The chaplain also visited him on 4 October after he was readmitted to hospital.

56. Following the man's death, the chaplain was appointed as the prison's family liaison officer. Because his family lived abroad, the duty governor informed them of his death in a telephone call the same morning. The chaplain liaised with the hospital, the coroner, the undertaker and the family. He helped with the funeral arrangements at the request of the family.

57. As requested by the man's family, funeral prayers were held at the East London Mosque after Friday Prayers on 14 October. An Imam represented the prison and participated in the prayers. The man's body was repatriated on 16 October. His brother received him on behalf of the family. The Governor of Brixton agreed that the prison would pay the costs of repatriation.

58. As the clinical reviewers comment in their review, the man was offered help to contact his family at the earliest opportunity. He also received a lot of support from the chaplain. It is commendable that the prison arranged for his body to be repatriated so promptly.

The man's location

59. When the man's condition rapidly deteriorated, he could not be admitted to the local hospice due to a lack of beds. Instead, he died in hospital. The clinical reviewers comment:

> 'The prison nursing and medical staff worked very hard to manage the man's condition in prison with advice from the palliative care team, until such time they could not manage it safely, at which time he was admitted to hospital via the emergency department.'

Release on temporary licence or early release on compassionate grounds

60. The man was an unconvicted remand prisoner and prison staff could not pursue the options available with a sentenced prisoner, such as release on temporary licence or early release on compassionate grounds. Instead, they pursued the option of bail to an address in the community.

61. The Governor, a prison doctor, a nurse and the prison's court liaison officer, liaised frequently with each other after the man received a terminal diagnosis. They contacted the Crown Court and the man's solicitor about the possibility of bail. On 9 September, the doctor prepared evidence for the man's bail application. The court agreed to consider the matter as soon as they received a letter detailing his circumstances.

62. At a meeting in Brixton on 12 September, the man's case was discussed by psychologists, healthcare staff and prison managers. The meeting was told that he had been diagnosed with terminal liver cancer and his health was rapidly deteriorating. Those present planned either to secure his release on bail or, if that was not possible, move him to a hospice as a serving prisoner with escort officers.

63. By 17 September, the man's solicitor believed he had good grounds for bail because of his client's ill health. However, suitable accommodation could not be arranged for his potential release on bail. It was thought that, because of his worsening health, he would be better cared for in prison until suitable accommodation in the community could be organised. The Crown Court reviewed his criminal case on 22 September in his absence. Because he did not have a suitable address to go to, bail was not granted.

64. Prison staff discussed the possibility of moving him to a hospice at a meeting on 26 September. The healthcare team supported this decision and notified the appropriate authorities. Staff at Brixton contacted the court listings department on 3 October. The court had received letters from his solicitor and the healthcare staff regarding his condition. However, his case was not scheduled to be reviewed again until 14 October.

65. Release on temporary licence (ROTL) was considered on 5 October, but it was confirmed with the national Sentencing Policy and Penalty Unit that ROTL only applies to sentenced prisoners, so this option could not be pursued. The only way forward was for the man's solicitor to apply to the court for bail. Unfortunately he died beforehand.

66. In these circumstances we are satisfied that the prison did all they could to provide a suitable environment for the man's last days.

Palliative care plans

67. The clinical reviewers comment in their review:

> 'There was continuous discussion with the community palliative care teams who were available for telephone advice and also visited the patient while in prison. Their support was very valuable in helping in general pain control… The medical team did explore the possibility of compassionate release and [a] letter of support was written by the medical team. The prison medical team is very experienced in dealing with terminally ill patients and end of life discussions, including 'Do Not Resuscitate' status, which was discussed fully with [the man].'

68. The man started chemotherapy. Unfortunately his condition continued to deteriorate quite rapidly and he was too poorly to be considered for a liver transplant. He was regularly monitored by the healthcare team who liaised with palliative care nurses at the hospital and a nearby hospice to ensure that his pain was managed appropriately. A palliative care nurse visited him in Brixton for a formal assessment and discussion with the healthcare team. When his condition deteriorated, a doctor decided that full-time palliative care was required and he moved to hospital.

Restraints, security and bed watch

69. The man was taken to hospital for the final time in an emergency ambulance on 2 October. Staff completed a risk assessment and concluded that due to

his deteriorating health he did not need to be restrained. We think that this was an appropriate, humane and sensible decision. He was not handcuffed and only one escort officer was required to be present with him at the hospital. The investigator found that the records of his stay in hospital were completed by officers appropriately and sensitively.

CONCLUSION

70. The man was diagnosed with liver cancer at hospital before his admission to Brixton. He was escorted to outpatient appointments without any delays. Despite starting chemotherapy, his condition declined rapidly. It was recognised at an early stage by clinical staff that he was terminally ill and a referral was made to the local community palliative care team.

71. He was admitted twice to hospital when his condition deteriorated. The prison healthcare team tried to arrange his admission to a local hospice but unfortunately there were no beds, so he was admitted to hospital to die. Sadly, as an un-convicted prisoner he could not be released on temporary licence and the courts had not agreed bail as he had no suitable address.

72. Both clinical reviewers found that the healthcare staff and the palliative care team managed the man's pain particularly well while maintaining his independence. They comment that the healthcare staff at Brixton worked well as a team and liaised well with the community palliative care team. They think that he received 'excellent care'. We do not make any recommendations as a result of the investigation.