PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at a hospice in March 2012, while in the custody of HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

June 2013

This is the report of an investigation into the death of a man who died in a hospice in March, 2012, while a prisoner at HMP Maidstone. The cause of death was cancer of the liver. He was 65 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer conducted a review of the man's clinical care on behalf of the local Primary Care Trust. HMP Maidstone cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man was diagnosed with cancer while at Maidstone and was referred to secondary care providers in a timely manner. However, before the start of the recommended course of treatment, his health deteriorated to the point where only palliative treatment could be given. The prison respected his wish to remain at Maidstone for as long as possible to benefit from the support of staff and his fellow prisoners.

It is unfortunate that consideration of the man's application for compassionate release was delayed by the probation trust, but overall, I am satisfied that he was well looked after at Maidstone. In my opinion, and that of the clinical reviewer, his care was at least equivalent to that which he would have expected to receive in the community.

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 **June 2013**

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SUMMARY

1. The man was convicted of serious offences on 16 October 2007, and remanded into custody at HMP Pentonville. On 1 November 2007 he was sentenced to 19 years in prison. He was 61 years old.

2. The man transferred to Maidstone on 11 November 2009. He had little significant contact with the healthcare department until 6 December 2011, when he saw a GP at Maidstone after reporting "high colour urine". After a series of tests and a referral to a urology clinic it was discovered that he had developed liver cancer.

3. On 5 February 2012, the man was admitted to hospital for surgery, but was found to have a chest condition making him unfit for the operation. An alternative date was arranged. Shortly before this he collapsed and was admitted to hospital. It was then concluded that his health had deteriorated to such an extent that surgery would not be possible.

4. The man's condition continued to get worse and on 15 March, he was transferred to a hospice. He died there in March 2012. His family were notified promptly and the prison arranged his funeral.

5. An application for compassionate release was inappropriately delayed while waiting for a report from the man's offender manager, but otherwise we are satisfied that his care was timely and appropriate, and at least the equivalent to that he could have expected to receive in the community.

THE INVESTIGATION PROCESS

6. Notices were issued announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.

7. The investigator visited HMP Maidstone and spoke informally to prison staff and collected a copy of the man's prison and healthcare records.

8. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf. He was given all relevant records to assist his review.

9. The investigation report has been sent to the Coroner to assist her enquiries into the man's death.

10. One of the Ombudsman's family liaison officers contacted the man's son on 30 April 2012, to explain the purpose of the investigation. He did not raise any matters for the investigation to consider and he was satisfied that the prison had cared for his father reasonably well.

11. 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.

12. This report was shared at the draft stage with the man's family. His son told us that he agreed with the report findings and had no comment to make.

13. The response of the Probation Trust is included after the recommendation in this report.

HMP MAIDSTONE

14. HMP Maidstone is a category C training prison holding almost 600 men.

15. The prison's healthcare unit has no in-patient facilities and does not provide 24 hour cover. GP services are provided by the NHS and three GPs provide cover on a rota basis. GP surgeries are held each weekday morning.

HM Inspectorate of Prisons (HMIP)

16. The last inspection of Maidstone was an unannounced inspection in September 2011. In relation to healthcare, HMIP found that low healthcare staffing levels impacted on their ability to be involved in wider prison meetings. The range of primary care services was appropriate, with short waiting times to see a GP. Prisoners told inspectors that healthcare staff were polite and respectful. Effective screening in reception identified needs quickly and appropriate referrals were made. Prisoners with chronic diseases were managed individually, as there were no formal clinics.

17. HMIP found that there was support for older prisoners using a "buddy" scheme (where other prisoners are paid a wage to help and assist an older person). Inspectors commented that "retirement pay was poor and some older prisoners worked to ensure they had sufficient funds". Older prisoners were unlocked during the core day, although there was often little access to structured activities. Palliative care was "supported by effective local links".

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, who help to ensure that prisoners are treated fairly and humanely. In the most recent IMB report for the year ending 29 February 2012 the IMB wrote:

> "There are no major shortcomings ascertained in the provision of healthcare to the prisoners in custody at Maidstone. The timeliness of appointments and range of services available in general is at least as favourable as that experienced by the public locally.
>
> "The additional health and wellbeing requirements of the older population are catered for."

Previous deaths at Maidstone

19. The man was the third prisoner to die at Maidstone since January 2011. There are no significant similarities between the circumstances of his death and those of the other cases.

ISSUES

20. On 16 October 2007, the man was convicted of serious offences and remanded into custody at HMP Pentonville. At his initial healthscreen, it was noted that he was suffering from cirrhosis of the liver, psoriasis and had been prescribed salbutamol to alleviate the symptoms of a previously collapsed lung. (Salbutamol is a drug used by inhaling to relieve bronchial conditions.) He was also noted to be suffering pain from a broken collar bone.

21. The man transferred to HMP Maidstone on 11 September 2009, where a nurse carried out an initial healthscreen. She noted that he was suffering from cirrhosis of the liver, sciatica and had only one fully functioning lung. She recorded that he was generally fit for work, albeit with restrictions.

The diagnosis of the man's terminal illness

22. After his initial healthscreen at Maidstone, the man had no further significant contact with healthcare until 6 December 2011, when he was seen by a GP at Maidstone after he reported passing "high coloured urine". The doctor carried out a urine sample test and noted the presence of blood. He made an immediate referral to a urology specialist at hospital.

23. On 20 December, the man was seen by the Urology Investigation Unit at hospital under the "two week rule" (a national target for patients with suspected cancer to be seen by a consultant within two weeks). He had a series of tests, an ultrasound of his kidneys, an X-ray of his abdomen and a flexible cystoscopy (when a thin, flexible, fibre optic telescope is passed into the bladder via the urethra). The results of these tests revealed nothing of note and he was referred the same day for a CT scan.

24. The CT scan was carried out on 6 January 2012 and indicated that there was an "extensive abnormality in the liver in line with malignancy". The man's spleen was also noted as being abnormally enlarged. He was referred to a gastrointestinal specialist.

25. A general surgeon saw the man on 18 January and diagnosed heptocellular carcinoma of the liver, the most common form of liver cancer. He immediately referred him to another hospital in London for treatment.

26. We are satisfied that when the man reported his symptoms he was reviewed promptly by the prison GP, who correctly referred him to specialist secondary care providers.

Informing the man about his condition and treatment

27. The general surgeon informed the man on 18 January that he had primary and secondary liver cancer. On 23 January, a GP at Maidstone spent some time with him ensuring that he understood the extent of his illness. He noted that he was upset and had many questions.

28. On 9 March, a GP noted the man's physical state and his declining health. At this consultation, he had a frank discussion with him about care and support from Macmillan nurses. The possibility of him requiring a transfer to a hospice for his end of life care was also discussed.

29. On 11 March, the man discussed with a nurse his wish to sign a "do not attempt cardiopulmonary resuscitation" form (DNACPR). The DNACPR gives a terminally ill patient the opportunity to note formally their wish not to be revived, or given advanced life support, in the event of either a cardiac or respiratory arrest. He was able to discuss his diagnosis with healthcare staff, who were responsive and acted promptly when he reported symptoms. Staff actively discussed his treatment with him. Unfortunately, a deterioration in his health meant that some of the proposed treatments could not be started.

30. We are satisfied, as is the clinical reviewer, that the man was promptly and fully informed of both the progression of his illness, and the treatment options that were available to him.

The man's medical appointments and treatment

31. After his referral to hospital, it was decided that the man would be suitable for a treatment using a procedure known as TACE (a procedure for passing anti-cancer medication into the blood vessel supplying the liver in an attempt to shrink the tumour).

32. An appointment was made for 5 February 2012, for the TACE procedure to be carried out. However, when the man attended hospital, it was discovered that he had developed a chest sepsis (a severe response to an infection). He was treated with antibiotics for five days before being discharged back to Maidstone.

33. A further appointment was made for TACE to be tried but the man was again taken ill and hospitalised on 12 March before that could be done. His condition by then meant that TACE was no longer a viable option.

34. We consider that all actions were appropriately documented in the medical records and it is clear that staff were thorough in following up treatments. The clinical reviewer considers that the man's assessed healthcare needs were met.

The man's pain relief and medication

35. The clinical reviewer found that the man was provided with appropriate pain relief and medication stating:

> "The clinical notes clearly record details of the medication and the patient's pain was regularly assessed by doctors and nurses".

36. We are satisfied that the man's pain relief was appropriately managed. He was prescribed pain relief which he kept in his cell and took as required.

Healthcare staff were responsive to his needs, and increased the medication as his condition changed.

Liaison with the man's family

37. The man maintained regular contact with his wife and son. On 16 February, after a visit from his wife, he informed a nurse that although his wife appeared to be coping well with the news of his illness, he was concerned about her. The nurse gave him his direct healthcare telephone number to pass onto his wife, so she could contact him personally to discuss her concerns.

38. As a result of his diagnosis the man was placed on an 'at risk' register at Maidstone. This is a system where terminally ill prisoners are supported by the family liaison team. A dedicated family liaison officer (FLO) is appointed at the prisoner's death. A member of the FLO team visited him in the hospice two days before his death, where he met the man's family.

39. When the man was in hospital he was lucid and was allowed to use the prison mobile phone (carried by the escorting officers) to speak to his wife on several occasions. When he moved to the hospice, the hospice staff kept his wife informed about his condition and she was able to visit him there.

40. The man died in March and the news of his death was broken to his wife by telephone by a nurse at the hospice. A FLO contacted his family that afternoon and visited them the next day and explained the procedures following a death in prison. Maidstone paid funeral expenses in line with national policy and the FLO maintained contact with the family until the funeral was over.

41. Maidstone invited the man's family to a memorial service held in the prison chapel.

42. While it is preferable to appoint a nominated family liaison officer as soon as a prisoner is diagnosed with a terminal illness, we are satisfied that the man's family received appropriate support. A nurse provided his telephone number to deal with any questions about his treatment and the FLO kept a detailed record of his contact with the family. We consider that he undertook this role well, with a sensitive and caring approach.

The man's location

43. After the man's diagnosis the nurse discussed with him a possible transfer to HMP Swaleside which, unlike Maidstone, has a healthcare inpatient unit. He declined the offer as he wanted to remain at Maidstone. This wish was respected.

44. The prison made adjustments to deal with the man's deteriorating health and mobility. This included special dietary requirements, provision of extra pillows to assist with fluid retention, and training in the use of a stair lift and buggy. In

his clinical review the reviewer remarks on the “high level of support” from both prison staff and other prisoners.

45. The man remained at Maidstone until 12 March 2012. After a fall in his cell, he was admitted to hospital and treated for a chest infection. A sudden deterioration in his condition led to him being transferred to a hospice in on 15 March, where he remained until his death.

46. The investigation found that the man was accommodated according to his wishes and that good efforts were made to provide appropriate aids and adaptations to meet his needs.

Compassionate release

47. Early release on compassionate grounds (ECR) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner’s care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

48. An application for early release on compassionate grounds was made on behalf of the man on 12 March and received at the PPCS that day. The application was not progressed because his offender manager, (probation officer) had not specified the arrangements for his release.

49. The Governor realised that the application for compassionate release might not be straight forward and authorised the man to be released on temporary licence on 13 March. We consider this was an appropriate decision.

50. A request for the missing information was made by the PPU on 14 March. The man’s offender manager replied on 15 March saying that after discussion with the assistant chief officer, no decision about the application would be made before a MAPPA (Multi Agency Public Protection Arrangements) meeting had taken place to consider the risks he posed to the public. He died a week later before a meeting was held.

51. For compassionate release to be granted, the prisoner must have a short life expectancy. Those suffering from terminal illnesses are prone to sudden deteriorations in health. When an application for compassionate release is made, time is often of the essence. At the time the man’s health had declined significantly and he had been released on temporary release licence, so a view about his risk must have been taken then. He moved to a hospice on 15 March, at which stage he was dying. If a MAPPA meeting was needed it

should have been held quickly. We consider the offender manager should have offered at least a provisional view to allow the application to be considered. The approach taken failed to recognise the urgency of the situation.

The Chief Executive of London Probation Trust should ensure that reports required for compassionate release applications are given appropriate priority

Palliative care plans

50. On 15 March, the man transferred to a hospice. At this stage the clinical reviewer notes that

> "Clear plans were made with the full input of the patient and an end of life pathway planned with the hospice."

51. There is no clear entry in the man's clinical records to indicate a palliative care pathway was started at Maidstone although there were entries made by a nurse on 9 and 11 March, in which it is apparent that the issue of end of life care had been discussed.

52. Maidstone's Palliative Care Policy document, dated February 2012, states that the prison had adopted the Liverpool Care Pathway for the Care of the Dying (a nationally recognised plan for providing palliative and end-of-life care in the last days or hours of life). The prison did not implement the Liverpool Care Pathway as the man did not spend his last days at Maidstone. He went to hospital on 12 March, and from there to a hospice where he received appropriate palliative care.

Restraints, security and bed watch

53. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.

54. On 12 March 2012, after a fall in his cell, the man was taken by emergency ambulance to hospital. It was agreed that he was low risk and no restraints were necessary. He was escorted by two officers.

55. On 13 March, a further risk assessment was made, when the man's health deteriorated further and he had been granted ROTL and he was accompanied by a single officer in civilian clothing. While we would question the necessity for an officer to accompany him when he was released on temporary licence, we agree it was appropriate that restraints were not used.

RECOMMENDATION *(service response below in italic)*

1. The Chief Executive of London Probation Trust should ensure that reports required for applications for compassionate release are given appropriate priority.

   London Probation Trusts accepts that it needs to make decisions in a timely way and would always endeavour to do so. Medical information had been sought to support the application but was never received. We had a previous case where we were asked to release and the individual recovered; it is for this reason we asked for medical information in order to undertake a risk assessment. However London Probation Trust agrees that the decisions should always be timely.