PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at hospital in December 2012, while a prisoner at HMP Risley.

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man, a prisoner at HMP Risley, in December 2012. He was 68 years old when he died. The post-mortem report found that he died from widespread cancer. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer from the local PCT reviewed the man's clinical care during his time in custody. HMP Risley cooperated fully with the investigation.

The man was diagnosed with prostate cancer in 2010 and his condition was monitored. On 21 December 2011, he reported abdominal pain and blood in his urine. It was then almost six months before he saw an urologist at hospital on 8 June 2012 and had a CT urogram (an X-ray used to examine the urinary system) and ultrasound. In July, tests noted a possible tumour in his ureter. In November, he had a scan which revealed numerous small nodules in his bones and throughout both lungs, which indicated cancer, the primary site of which could not be detected. No curative treatment was possible.

The post-mortem report suggests that the man did not, after all, have prostate cancer. However, healthcare staff at the prison were obliged to act on that diagnosis and the clinical reviewer considered that that he received good care in that respect. The pathologist was unable to detect the primary tumour which led to his death, which the clinical reviewer indicates makes it very difficult to say whether anything could have been done to detect his cancer earlier.

Overall the clinical reviewer was satisfied that the care and treatment the man received at Risley was of a good and professional standard. It is, however, of concern that an application for his early release on compassionate grounds was not processed properly.

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 2013**

CONTENTS

SUMMARY

1. The man was convicted of serious offences on 15 July 2011, and was sentenced to five years and six months imprisonment on 5 September 2011. He was sent to HMP Preston the same day, and transferred to HMP Risley on 8 December.

2. In 2010, before going into prison, the man was diagnosed with prostate cancer. As prostate cancer is slow-growing, he did not receive treatment but instead saw his consultant every three months when his PSA (prostate-specific antigen, a substance produced by the prostate gland) levels were checked. At Risley, he had his PSA levels checked at the prison as he did not want to go to hospital in handcuffs.

3. On 21 December 2011, the man complained of blood in his urine with left-sided abdominal pain. He was referred to an urologist, but did not have an appointment for nearly six months. On 8 June 2012, a flexible cystoscopy examination (which uses a camera to examine the inside of the bladder) was conducted but did not show any bladder abnormalities. A CT urogram (an X-ray used to examine the urinary system) and ultrasound on 2 and 9 July showed a possible tumour in the left ureter.

4. On 19 September, after the man complained of shortness of breath with a cough that produced white and green phlegm, he was diagnosed with chronic obstructive pulmonary disease, COPD (a disease of the lungs in which the airways narrow over time). A chest X-ray, on 25 September, revealed no abnormalities.

5. A prison doctor reviewed the man again on 5 November. He complained of feeling tired and having difficulty walking long distances due to back ache. He now weighed 9st 6lb, a loss of 3st 5lbs since December 2011. He was referred for a CT scan (a three dimensional X-ray) of the chest, abdomen and pelvis, which showed numerous small nodules in his bones and throughout both lungs, consistent with lung metastases (metastases is the spread of a cancer from one organ or part to another non-adjacent organ or part). The left adrenal gland was enlarged and abdominal lymphadenopthy (disease of the lymph nodes) was also present.

6. Whilst the clinical reviewer believes that the man received generally good care in prison, there was at least one occasion when prison healthcare staff could have made more urgent hospital referrals. While it does not seem a delay would have altered the outcome for him, it might have meant his terminal condition was detected earlier. His application for release on compassionate ground was not actioned because a member of staff was absent. His next of kin was unhappy that his clothes were returned unlaundered and Risley did not follow Prison Service guidance about consulting a deceased prisoner's family about arrangements for returning property.

THE INVESTIGATION PROCESS

7. After the PPO was notified of the man's death, we obtained his prison files and medical records from the prison. Notices were issued to staff and prisoners at HMP Risley asking anyone with information about his death to contact the investigator. No one came forward.

8. Interviews were not conducted for this investigation. The quality of the prison records allowed the investigator to carry out a full investigation without the need to visit the prison.

9. A review of the clinical care the man received in prison was conducted by a clinical reviewer, who was appointed by the local PCT.

10. A copy of this report has been sent to the local coroner's office.

11. One of the Ombudsman's family liaison officers contacted the man's ex-wife. She explained the investigation process and asked if there were any issues she wished to be considered as part of the investigation. The man's ex-wife said that she had been treated very well by staff at Risley but had the following concerns:

    - He could not sit up in bed because he was in a lower bunk. .
    - When he went out to hospital the final time it took 4.5 hours to for the ambulance to arrive and then take him to the hospital.
    - When his possessions were returned, his clothing had not been laundered.

12. The man's ex-wife received a copy of the draft report and was given the opportunity to comment on the contents. She explained that she was unaware about the application for compassionate release, and was surprised to learn it had remained in an in-tray while someone was on holiday. She further commented that her ex-husband told her that once he was diagnosed with cancer, the staff treated him very well and saw to his needs.

HMP RISLEY

13. Risley is a Category C training prison which holds around 1,000 adult male prisoners. Primary healthcare services are provided by the NHS. Risley has 24 hour nursing care and on-call medical cover. There is no in patient facility.

Her Majesty's Inspectorate of Prisons (HMIP)

14. HM Inspectorate of Prisons conducted a full announced inspection of Risley in February 2011, and commented:

> "Relationships between the prison and NHS agencies were good. There was an appropriate range of primary care and life-long condition clinics … There was a good system to notify patients about outcome of diagnostic tests. A PCT palliative care policy included the Liverpool end of life care pathway. Several prisoners were at different stages of end of life care, for whom individual care packages were arranged including the use of local Macmillan nurses and hospice services."

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their most recent annual report for Risley for the year to March 2012, the IMB commented:

> "The healthcare facility at HMP Risley aims to provide a health service that is equivalent to primary care services provided to NHS patients within the Warrington community. The number of applications received from prisoners regarding Healthcare issues has increased from 26 to 30 [since their last report]. This increase has mostly been with regard to prescription drugs, prisoners requesting certain medication and either being offered alternative medicines or refusal. A new model of GP Practice has been introduced which has significantly reduced the need for locum GPs, this should improve the continuity of GP care".

Previous deaths in custody

16. Since 2011, we have investigated nine deaths at Risley, including the man's death and two deaths subsequent to his. None of the circumstances of those deaths are relevant to this investigation.

ISSUES

The diagnosis of the man's terminal illness

17. The man was convicted of serious offences on 15 July 2011, and was sentenced to five years and six months imprisonment on 5 September 2011. He was taken to HMP Preston the same day.

18. The man had been diagnosed with cancer limited to his prostate gland in 2010. He was not receiving treatment but was being actively monitored. This type of treatment is called 'watch and wait'. Prostate cancer is generally a slow-developing cancer and active surveillance is often used rather than aggressive treatment. Cancer specialists take into account PSA levels, how the prostate cancer cells look under a microscope (the Gleason score) and the size of the prostate gland before deciding on treatment. (For most men, a normal PSA level is 4ng/ml. PSA is prostate-specific antigen a substance produced by the prostate gland.) He had been advised that he would be reviewed by his consultant every three months to monitor his raised PSA levels. His most recent hospital appointment before arriving at Preston was in August 2011 when his PSA level was 12.8ng/ml.

19. When he arrived at Preston, the man told the nurse in reception that he was under the care of a doctor at hospital for prostate cancer and had an appointment for 23 November. On 21 November, he informed the prison healthcare department that he did not want to attend his next oncology appointment and signed a medical disclaimer form. He explained that he had been to the hospital every three months before coming to prison and at his last appointment his consultant did not have any concerns. He said that he did not want to attend hospital restrained.

20. The man transferred to HMP Risley on 8 December. On arrival, his weight was 12st 11lb and his blood pressure at 119/80, was normal. He was referred to see the prison GP because of his prostate problems.

21. A prison GP saw the man on 12 December and he asked for his PSA levels to be checked in prison. He said that he only wanted to be referred to hospital if anything abnormal was detected. He did not have any other symptoms. His PSA levels result on 13 December was slightly raised at 6.6ng/ml which the clinical reviewer considered was not an issue.

22. On 21 December 2011, the man saw a doctor for a follow-up appointment and reported blood in his urine and left-sided stomach pain. His abdomen was found to be tender but no mass was detected. A rectal exam confirmed that his prostate was enlarged but the doctor did not consider this abnormal in the light of his diagnosis. His weight was now 12st 4lb, a loss of 7lbs in 13 days. A non-urgent referral was made for him to be seen by an urologist.

23. On 11 January 2012, the man saw a doctor again and said he had experienced only one further episode of blood in his urine, but still had abdominal pain. He was still waiting for his urology referral, which the doctor

said he would chase. On 5 April, a letter was eventually received from the hospital confirming an urology appointment for 12 June.

24. On 18 May, a doctor saw the man after he had complained that he had had blood in his urine and abdominal pain for the previous four days. He also said he felt light headed. The doctor was aware that he had a hospital appointment for 12 June but, because of his symptoms, made a two week (cancer) referral to bring this forward. He prescribed tramadol to relieve his pain.

25. Three weeks later, on 8 June, an urologist at hospital saw the man. In a letter to the prison, an associate specialist in urology commented that he had seen him in August 2011 (before he went to prison). Although he had blood in his urine, he did not have any other lower urinary tract symptoms. His prostate felt moderately enlarged but the doctor could not feel any clinical changes from his previous examination. A flexible cystoscopy (a medical procedure used to examine the inside of the bladder) was conducted that day but did not show any bladder abnormalities. The specialist arranged for him to have a CT urogram (an X-ray used to examine the urinary system) and an ultrasound. These were conducted on 2 and 9 July.

26. On 13 July, an urologist at hospital told the man that his CT urogram had revealed a blockage in the left ureter (the ureter are fibres that take urine from the kidneys to the bladder) which suggested that he might have a tumour and arranged an urgent examination of the upper urinary tract on 23 July. The outcome of this is not recorded in his medical record.

27. On 5 September 2012, the man saw an advanced nurse practitioner when he said he had had a cough for four weeks, was breathless when walking fast or up stairs and had a poor appetite. His weight was 10st 5lb, a loss of 33lbs since 8 December 2011. His chest was crackly when examined and the nurse diagnosed an acute lower respiratory tract infection. She prescribed prednisolone (an anti-inflammatory steroid medication used for asthma patients) and co-amoxiclav (an antibiotic).

28. On 12 September, the man told a healthcare assistant at the prison that he was finding it more difficult to pass urine and that he had not previously mentioned this to the nurse or doctor. A prison GP saw him on 19 September, when he said he was experiencing shortness of breath and producing white and green phlegm when he coughed. The doctor thought that he might have chronic obstructive pulmonary disease, (COPD - a disease of the lungs in which the airways narrow over time). His weight was recorded as 10st 1lb (a further loss of 4lbs). The doctor prescribed Fortisip build-up milkshakes, asthma inhalers and ipratropium, a drug used for COPD. He was booked for an urgent chest X-ray and spirometry to measure his lung function. A chest X-ray at hospital on 25 September showed nothing abnormal.

29. The doctor reviewed the man again on 5 November when he complained he felt tired all the time and was having difficulty walking long distances due to back ache. He now weighed 9st 6lb. The doctor telephoned the radiologist at

hospital for advice. The radiologist advised a CT scan (a three dimensional X-ray) of the chest, abdomen and pelvis in light of his known prostate cancer, his weight loss and general deterioration.

30. The man had a CT scan at hospital on 16 November, which showed numerous small nodules in his bones and throughout both lungs consistent with lung metastases (metastases is the spread of a cancer from one organ or part to another non-adjacent organ or part). His left adrenal gland was enlarged and abdominal lymphadenopthy (disease of the lymph nodes) was also present. One of his kidneys appeared abnormal. The primary site of the cancer could not be detected. In a letter to the radiologist, a doctor noted that "there is no evidence of sclerotic [bone] metastases which I would expect with a prostatic [prostate cancer] primary".

31. The man's condition deteriorated and he was admitted to hospital on 20 December where he died a few days later.

32. The man was diagnosed with prostate cancer in 2010 before he went to prison for which he was under the care of a hospital consultant. In relation to his subsequent diagnosis of widespread cancer, the clinical reviewer commented that, in December 2011, when he reported blood in his urine, pain and weight loss, a two week cancer referral could have been made than rather than a normal urology referral. As the healthcare staff knew that he was already diagnosed with cancer of the prostate gland and under the care of a urologist it was understandable for the prison doctor to assume that his problems were related to his pre-existing condition. The clinical reviewer believes that it would have been appropriate for the healthcare team to have secured an earlier appointment with the urologist but did not consider the delay had any bearing on the outcome or prognosis. When he eventually saw the urologist in June 2012, nothing untoward was found. Further tests in July found that a tumour in his ureter was suspected but it is not clear how this was followed up by the hospital. At the beginning of November one of the prison doctors was concerned about him and telephoned the hospital radiologist for advice. The clinical reviewer considers this was a commendable initiative. This led to further tests which resulted in him being diagnosed with lung metastases.

33. The clinical reviewer's opinion was that the findings of the post-mortem report made it difficult to say if anything could have been done to detect the primary tumour that led to the man's death. However, there was a delay in him receiving a urology appointment at hospital early in 2012, when he waited six months. Three months passed before the appointment was chased for a second time. While it does not appear that this would have affected the ultimate outcome for him, it is possible that an earlier referral would have led to an earlier diagnosis of his terminal illness. We make the following recommendation:

The Head of Healthcare should ensure that urgent referrals to hospital are made whenever there are serious concerns about the health of a prisoner suspected of having, or being treated for, cancer.

Informing the man about his condition and treatment

34. On 21 December 2011, when the man complained of blood in his urine with left-sided stomach pain, a non-urgent referral was made for him to be seen by the hospital urologist. The reason for this referral was explained to him.

35. On 20 November 2012, after the man had attended hospital for a CT scan, the prison doctor saw him to discuss the results. The doctor explained that he had metastatic lesions in his bones, lungs and adrenal glands. He was told that a hospital appointment had been made for him for 30 November to discuss possible treatment options with his specialist. According to his prison medical records, the doctor "explained the gravity of his condition". He declined to attend hospital on 30 November as he had a visitor coming to see him, so his appointment was rebooked for 10 December. After this appointment, the urologist wrote to the doctor and said that his further care would be discussed following the next urology team meeting. He died before this took place. Palliative radiotherapy had been considered as an option but no curative treatment was possible.

36. The clinical reviewer was satisfied that the man was given full information on the reason for referral to hospital, and he was informed of his diagnosis in a timely manner following the scans in November 2012.

The man's medical appointments and treatment of the prisoner

37. Before he was convicted, the man attended hospital every three months for monitoring. He had his PSA levels checked in prison as he did not wish to attend hospital in handcuffs.

38. After he was diagnosed with terminal cancer in November 2012, the man attended one meeting at hospital, on 10 December. He had a further appointment booked for 21 December, but this was cancelled the day before as he was too ill to attend. (Because of his rapidly deteriorating condition he moved to hospital for end of life care on 20 December.)

The man's pain relief and medication

39. Before his terminal diagnosis the man had complained of abdominal pain and a doctor prescribed tramadol in May 2012, which appeared to control his pain for several months. On 29 October, the prescription was changed to co-codamol after he complained of increased back pain.

40. A doctor prescribed oramorph, dispensed in tablet form, when the man reported increased pain on 10 December. On 18 December, staff considered whether he could keep his oramorph in his cell in a locked cabinet so that he could self-administer pain relief. The prison's security department advised that this would bring attention to the medication and that the cabinet could be kicked off the wall. We are surprised that it was not possible to provide secure storage for this medication. However, his pain was monitored

regularly by staff and although it would have been preferable for him to be able to self-administer, he does not seem to have been disadvantaged by not having oramorph in his cell.

41. Palliative care anticipatory drugs were prescribed for the man and the prison pharmacy was asked to keep these in stock. These included diamorphine (a strong painkiller), cyclizine (an anti nausea medication), midazoloam (a sedative), glycopyrronium (used in asthma and COPD and which reduces phlegm).

42. The clinical reviewer was satisfied that the man was given appropriate pain relief and medication in prison.

The man's location

43. The man lived on G wing at Risley in a double cell with bunk beds. The cell was large enough to allow wheelchair access. He was the sole occupant. On 29 October 2012, after he complained of increased back pain, the top bunk was removed to enable him to sit upright in his bed.

44. On 22 November 2012, a healthcare administrator asked the palliative care service at the hospital for advice about how to keep the man comfortable and about any aids that were available. At this time he used a wheelchair and walking stick.

45. The same day, the man was visited in his cell to discuss his future care. He said that he did not want to be transferred to HMP Preston's inpatient unit. He said that he was from the Wirral and would like to go back there if possible and hoped to get compassionate release.

46. The man was able to remain in his own cell after extra equipment was provided. He was given a profile bed (an electric bed that can be used in multiple positions), a three-wheeled walking frame and a commode for use in his cell. Agency nurses assisted him with his personal care needs.

47. In December, a doctor visited the man in his cell and thought that his condition was deteriorating and it was becoming more difficult to manage his pain effectively. He then agreed that the best place for him would be in a hospice or hospital. He was taken to hospital at 5.30pm that day, where he died three days later.

48. The man's ex-wife asked why it had taken over four hours for an ambulance to take him to hospital on 20 December. The ambulance was called at approximately 2.00pm and left the prison at 5.30pm. Any delay is a matter for the ambulance service and not within the remit of this investigation. This was not an emergency ambulance and we are satisfied that he was not adversely affected by the wait. Two nurses remained with him until the ambulance arrived. He was asleep for most of the time and the nurses gave him oxygen as required.

49. We consider that the man was appropriately located in Risley and satisfactory efforts were made to meet his physical needs. The prison arranged a move to hospital when he needed more intensive care at the end of his life. He was due to move to a hospice on 23 December, but died before the move could take place.

Liaison with the man's family

50. The man's next of kin was his ex-wife. After being told of his terminal diagnosis on 20 November 2012, he contacted her. On 19 December, with his permission, the healthcare manager called his ex-wife to update her and arranged for her to visit him in his cell. The next day his ex-wife was informed when he moved to hospital.

51. The man's ex-wife and his son visited him in hospital that evening. The escorting officers moved away from the bed to allow him some privacy with his family. His family remained with him until 3.45am the next morning. His ex-wife gave the officers a contact telephone number in case he died that day.

52. A principal officer was appointed as family liaison officer a couple of days later. She contacted the man's son to tell him that his father was transferring to a hospice later that day. The family were due to visit him the next day but he died that evening. The escort officers called her to inform her of the man's death and she contacted his son to tell him that his father had died. His mother was with him and he said he would break the news to her.

53. The prison assisted appropriately with funeral arrangements, which was held on 18 January 2013.

54. The man's ex-wife was surprised that his clothes had been returned to her unlaundered. She said that the prison's family liaison officer had told her that many people preferred this. Prison Service instruction, PSI 064/2011 specifically requires that the prison should ask families of deceased prisoners how they want property returned, including whether they want clothes laundered. It is regrettable that the instruction was not followed and we make the following recommendation:

    The Governor should ensure that families are asked how they want a prisoner's property to be returned after a death in custody.

Compassionate release

55. Early release on compassionate grounds (ERCG) 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 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) within the National Offender Management Service (NOMS)

56. When the prison doctor saw the man on 20 November to discuss his cancer diagnosis, he told him that he would speak to the Healthcare Manager about making an early release application for him. The doctor completed his section of the application that day but the rest of the form was blank. The investigator was told that ERCG applications were sent to the prison's offender management unit (OMU) and given to a case administrator to pass to the prisoner's offender supervisor for completion. However, his application remained in the administrator's in-tray as she was absent on sick leave. The application form was not found until after his death.

57. Clearly this was unacceptable. Since the man's death, we have been told that new procedures have been implemented to help prevent a repeat. Once the doctor has completed their part of the ERCG form, it is sent to the OMU manager and logged before passing to others for completion. As applications for compassionate release are not started until a prisoner is near death with a terminal illness, it is important that applications for compassionate release are given priority and completed quickly. While Risley have changed the process for handling applications, this also seems to rely on one member of staff (the OMU manager) being available to ensure the application is logged and progressed. We make the following recommendation:

The Governor should ensure that all applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised and completed without delay.

Palliative care plans

58. On 18 December, a doctor discussed palliative care anticipatory drugs for the man with the District Nurse, and appropriate drugs were prescribed. The same day, the advanced nurse practitioner spoke to him about moving to a hospital or a hospice and they discussed the use of a DNAR (do not resuscitate order). He said that he would speak to his family and let her know next week.

59. The man was transferred to hospital on 20 December, with a plan to transfer him to the local hospice. He died before space became available.

60. There is no record of a formal written end-of-life pathway for the man while he was at Risley, although we recognise that his condition deteriorated quickly before he was taken to hospital on 20 December 2012. However, the elements of an end of life care plan were put in place including appropriate provision for pain relief, family liaison and discussions with him about his wishes. Before he left the prison he was given the opportunity to say goodbye to his friends. The clinical reviewer is satisfied that after he left Risley an appropriate end-of-life pathway was followed.

Restraints, security and bed watch

61. The man was taken to hospital at 5.30pm on 20 December 2012. He was escorted by two officers. He was assessed as being a low risk and restraints were not used.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that urgent referrals to hospital are made whenever there are serious concerns about the health of a prisoner suspected of having, or being treated for, cancer.

   The National Offender Management Service responded with,

   Accepted - Where new cancer cases are suspected patients are referred to appropriate services under the 2-week rule arrangements. This is audited monthly. In this particular case, it was understood that the patient was already being treated for prostate cancer and had Consultant Urology appointment. The reviewer made comment about this in his review. However, the wait for an appointment of 6 months is excessive – all cancer related referrals are now reviewed through a tracker system and now include trigger points where a referral exceeds an expected time frame. This is monitored and managed by the office manager.

2. The Governor should ensure that families are asked how they want a prisoner's property to be returned after a death in custody.

   The National Offender Management Service responded with,

   Accepted - Issue referred to Risley's Safer Custody Department for any future DIC incidents and all FLOs to made aware of this issue as part of the procedure when liaising with the families of deceased prisoners

3. The Governor should ensure that all applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised and completed without delay.

   The National Offender Management Service responded with,

   Accepted - This matter has been referred to the OMU and Healthcare Departments as Risley has recently undertaken a review of the procedure for applications for release on compassionate grounds and a protocol for this is being finalised.