



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital while
in the custody of HMP Leeds in February 2013**

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 investigation report into the death of a man, a prisoner at HMP Leeds. He died from skin cancer at hospital in February 2013. He was 68 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a clinical review of the standard of healthcare the man received at HMP Leeds. The prison cooperated fully with the investigation.

The man had a number of medical conditions when he arrived at the prison in December 2011, including a recent diagnosis and treatment for skin cancer, bowel disease, asthma and arthritis. He continued to receive treatment for skin cancer after several lesions were found on his body. At the end of January 2013, it was discovered that his cancer had spread. His condition was terminal, but he was expected to live for a further 12 months and he was due to be released on 5 March.

One morning in February, just days after he had been told he had terminal cancer, his health deteriorated very suddenly. He was immediately taken to hospital but died there shortly afterwards.

The clinical reviewer concludes that the man received appropriate care at Leeds and staff reacted correctly by taking him to hospital immediately when they found him very unwell on the morning of his death, which was sudden and unexpected. However, we are concerned that palliative care planning did not start earlier than it did once his diagnosis was confirmed, particularly as he was due for release very soon. He also had limited mobility and was in very poor health, but this does not appear to have been fully taken into account in risk assessments to determine the required security arrangements when he was taken out of the prison for hospital appointments.

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

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SUMMARY

1. The man was remanded to HMP Leeds in December 2011. He had been facing criminal charges but had breached his bail conditions. At his initial health screen he told a nurse that he had asthma, Crohn's disease, arthritis and was being treated for skin cancer. The prison GP examined him and then wrote to his skin consultant about a lesion on his back. In March 2012, he had a biopsy on the lesion, followed by surgery two months later.
2. In June 2012, the man received a custodial sentence from which he was due to be released on 5 March 2013. In September, a hospital consultant noted an abnormality under his armpit and referred him for a biopsy, which the hospital cancelled in December. Instead he had surgery in January 2013 to remove a lesion from under his arm.
3. On 28 January, a hospital consultant told the prison GP that the man was not likely to live for more than a year and suggested palliative care should begin. The GP did not tell him about his terminal diagnosis and prognosis until 18 February, when he received written confirmation from the hospital consultant about his diagnosis and prognosis.
4. One morning in February at 9.50am, the man was found unwell in his cell. He was cold and had low oxygen levels, so he was taken to hospital in an emergency ambulance at 10.16am. His condition quickly deteriorated at hospital, and he was pronounced dead at 11.50am.
5. The investigation found that the man did not yet have a palliative care plan to help ensure continuity of care after his expected release. His medical condition and mobility were not fully taken into account when he was risk assessed for his escorts to hospital appointments, but otherwise the general standard of his medical care at Leeds was appropriate.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was notified of the man's death on 21 February 2013. The investigator issued notices informing staff and prisoners of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of the man's medical record and relevant prison records. The local PCT appointed a clinical reviewer to review the man's clinical care at HMP Leeds.
8. On 3 April, the investigator visited the healthcare unit at HMP Leeds and the wing where the man had lived.
9. The investigator informed HM Coroner for West Yorkshire Eastern District of the investigation. A copy of the report has been sent to the Coroner to assist his enquiries.
10. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation. They did not have any specific concerns for the investigation to consider.
11. The investigation has assessed the main issues 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.

HMP LEEDS

12. HMP Leeds, in West Yorkshire, is a local prison holding up to 1,120 male sentenced and remand prisoners.
13. At the time of the man's death, healthcare services were commissioned by NHS Leeds and provided by Leeds Primary Care Trust. During the day there is full healthcare cover, including a doctor, while at night there is nurse cover. There is an inpatient unit of six beds.

HM Inspectorate of Prisons

14. HM Chief Inspector of Prisons carried out a full announced inspection of HMP Leeds in January 2013 shortly before the man's death. The Inspectorate found that the prison was successful in promoting good staff and prisoner relationships and prisoners were treated with respect. Inspectors found that the range of health services was good and that there were effective links with local Macmillan nurses and hospices. End of life training had started and a policy was being formulated.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the community who monitor all aspects of prison life to help ensure that proper standards of decency are maintained. In its report for the year to December 2011, the IMB noted that the healthcare centre had been refurbished and there had been a significant improvement to a number of cells. There were plans to reduce the role of the healthcare centre and focus on the delivery of healthcare on the wings.

Previous deaths in Leeds

16. The man's death was the third death from natural causes since 2011. Each of the previous deaths had been foreseeable and we found good palliative care. We repeat a recommendation made in one of the previous investigations to ensure that escort risk assessments take into consideration the medical condition of a prisoner.

ISSUES

The diagnosis of the man's terminal illness

17. The man had already been diagnosed with skin cancer when he was taken to prison for failing to adhere to bail conditions on 7 December 2011. He was receiving treatment from a skin specialist at hospital.
18. At his initial health screen, the man told the prison doctor that he had rheumatoid arthritis, asthma and Crohn's disease (an inflammatory bowel condition, which meant he had a colostomy bag). After the health screen, the doctor wrote to the hospital about a lesion on the man's back. In March 2012, he had a biopsy followed by a surgical procedure in May to remove the malignant (cancerous) lesion. After the surgery, he was told that he would not need radiotherapy or chemotherapy.
19. After examination at a hospital check up on 25 October 2012, a hospital doctor referred the man for a surgical biopsy on a gland under his armpit. On 20 December, he attended hospital for day surgery, but a doctor cancelled the procedure and instead arranged for him to be admitted to hospital in January for surgery under general anaesthetic.
20. On 18 January 2013, the man was admitted to hospital for the surgical procedure and body tissue was removed for histology analysis as the consultant suspected that his skin cancer had spread. On 28 January, a hospital consultant told the prison doctor that the man's cancer had spread to the lymph nodes, he was terminally ill and had less than a year to live. The prison received written confirmation of the terminal diagnosis and prognosis on 18 February.
21. The man's skin cancer had already been diagnosed before he went into custody. We agree with the clinical reviewer that the prison acted appropriately to ensure that complications of his condition were identified by his consultant and an appropriate further diagnosis was made.

Informing the man about his condition and treatment

22. The man knew that he had skin cancer when he first came to prison. On 28 January 2013, the hospital consultant told the prison doctor that the results of the surgery had shown that the man was terminally ill. He had only a 25 per cent chance of survival for more than five years and he was not likely to live more than a year. The consultant suggested he might benefit from palliative care. The doctor decided to wait until he had confirmation of the prognosis in writing before he discussed the results with him.
23. The doctor saw the man on 4 February, and they discussed his recent surgery and his medication. The doctor did not yet have the written information from the hospital, so he did not mention his terminal condition and prognosis during this discussion.

24. At 5.45am on 18 February, officers asked a nurse to check the man. The nurse noted that he had been coughing and spitting blood and phlegm. She checked his observations and recorded him as having a normal temperature, pulse rate and blood pressure. He was anxious and fearful and told her that he thought his cancer might have spread. The nurse established with him that this had not been confirmed by the doctor.
25. At 9.00am, that morning a healthcare administration worker telephoned the man's hospital consultant for urgent written confirmation of his prognosis and the outstanding results which were then faxed to the prison. The prison doctor spoke to the consultant before he saw the man at 9.25am with a nurse. The doctor explained the outcome of the surgery on 18 January. He told him that he was unlikely to live for more than 12 months. He was upset, but told the doctor that he wanted to stay on the wing at Leeds with his friends. A nurse then spent some time with him to support him.
26. The prison doctor had been told about the seriousness of the man's condition, but did not tell him for three weeks, as he wanted first to wait until the diagnosis was confirmed in writing. As the doctor had been told that his life expectancy was up to 12 months, the clinical reviewer considers this was a reasonable approach and we agree. We are satisfied that he was given appropriate support once he had been told about his limited prognosis.

Medical appointments

27. The prison doctor wrote to the man's hospital consultants in December 2011, raising his concerns about a suspected malignant lesion on his back. The hospital cancelled his appointment for a biopsy on 15 February, and it was then rearranged for 2 March at another hospital.
28. The man missed an early morning outpatient appointment on 1 February because an escort had not been arranged by the security department. Healthcare administration staff contacted the hospital straight away and later that morning he was taken to the hospital for the rearranged appointment. Although the original time of the appointment was delayed, we are satisfied that healthcare staff worked quickly to ensure that his treatment was not compromised. We agree with the clinical reviewer that his treatment was appropriately facilitated by the prison, in line with the hospital consultant's advice.
29. The man was found very ill in his cell a few weeks later. Staff acted appropriately in arranging an emergency admission to hospital, but sadly he died shortly after arrival.

Palliative Care

30. On 28 January, the hospital consultant suggested to the prison doctor that the man should be given palliative care, but the doctor decided to wait for written confirmation of his prognosis, which was received on 18 February. There is

no evidence that Leeds healthcare staff made any arrangements for palliative or end of life care.

31. Early palliative care plans are important to help ensure prisoners get quality terminal care and that their emotional, physical and spiritual needs are met through a multi-agency approach. These plans take time to coordinate to reflect the patient's wishes and medical needs.
32. The prison doctor was told of the man's prognosis five weeks before he was due to be released and had written confirmation on 18 February. He died very suddenly just three days later. We are concerned that no palliative care plan had been started after his terminal diagnosis was communicated to him and that, at the time of his death, just two weeks before his planned release there was still no plan in place.

The Governor and Head of Healthcare should ensure that an end of life pathway is used for all terminally ill prisoners to ensure a multidisciplinary approach to managing prisoners at the end of their lives and to provide continuity of care for those due to be released.

The man's pain relief and medication

33. The man was prescribed simvastatin to lower cholesterol, omeprazole (an antacid medication), salbutamol for asthma and medication to manage his arthritis. On 24 November 2012, he was prescribed a nutritional supplement to help maintain his weight. He was prescribed a short course of sleeping medication (zopiclone) on 13 February.
34. After his surgical procedures, the man was prescribed paracetamol and co-codamol for pain relief. After his surgery in January 2013, he was prescribed tramadol, a morphine-based pain killer. There is no record that he complained of pain to nurses or requested additional pain relief.
35. We agree with the clinical reviewer that the man's pain was managed appropriately and his medication was appropriate to his needs.

The man's location

36. After the man's surgery in January 2013, he was given a single cell on the ground floor of his wing near the wing office.
37. The prison doctor suggested that the man should be admitted to the healthcare centre, but he said he preferred to be on the wing with his friends, who assisted him with his day to day living. We agree with the clinical reviewer that prisoners should stay where they are most comfortable for as long as possible and we are satisfied that his wishes were respected while he was in prison.

Restraints, security and bed watch

38. 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. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that a medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely to be regarded as inhumane unless justified by other relevant considerations.
39. The investigator reviewed the restraint risk assessment documents for the man's hospital visits. His risk of escape was assessed as low throughout his time at Leeds, but he was considered a medium risk to children, because of his offence. Officers used an escort chain to restrain him each time he went to hospital. (An escort chain is a length of chain with one cuff attached to the prisoner and another cuff to an officer.) On his escort risk assessments, it was noted that he should only be restrained by a chain because he used a walking stick. There was no recorded assessment of how his physical health might impact on his risk to the public or his risk of escape. When he was taken to hospital as an emergency in February 2013, he was not restrained.
40. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. There is no evidence that the man's serious medical condition and restricted mobility was taken into consideration when assessing his level of restraints, so we cannot conclude that his risk was properly assessed.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

Compassionate release

41. 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 for determinate sentenced prisoners are usually expected to have less than three months to live.
42. The hospital consultant estimated that the man would live for 12 months, so such an application was unlikely to be successful. As he died unexpectedly

only days after his diagnosis, we accept there was insufficient time to consider and pursue an application for compassionate release.

Liaison with the man's family

43. The man's family lived in the South West of England and he kept in touch by telephone and letters. When he was told about his prognosis on 18 February 2013, a nurse spoke to him about informing his family of his condition. With his agreement, the nurse rang his daughter the next day and told her of her father's terminal illness. She said she had been unable to visit her father because it cost too much to travel that far. The nurse told her she would see if there was any available assistance for a visit and, in the meantime, arranged for him to have a private telephone call with his daughter on 20 February.
44. A prison family liaison officer (FLO) went to the hospital when the man was taken in. She arrived at 11.50am when hospital staff were attempting to resuscitate him. He was pronounced dead shortly afterwards and, at 12.05pm, she telephoned his daughter to inform her of her father's death.
45. Prison Service Instruction (PSI) suggests that the news of a prisoner's death should be broken to his family in person wherever possible. If a prisoner's family is a long distance from the prison, the prison must consider asking a FLO from a prison nearer the prisoner's family to break the news. There is no evidence that the prison considered contacting a prison in the South West, in line with the requirements of the PSI.

The Governor should ensure that wherever possible a Prison Service representative visits the next of kin in person to break the news of a death in custody.

46. The FLO kept in touch with the man's family, and helped with funeral arrangements. She collected his belongings from his cell and visited a probation hostel to collect some of his property that was stored there.
47. The funeral was held in Plymouth on 12 March. The FLO represented the prison at this service and handed to his family his property. A memorial service was held in the prison chapel for his friends. The prison contributed towards funeral expenses.
48. Despite the man's terminal illness, the very sudden deterioration in his health and his death were unexpected. A nurse told his daughter that her father was terminally ill and was in the process of providing information to help fund a family visit. He spoke to his daughter the day before he died. We consider that family liaison arrangements were managed appropriately.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that an end of life pathway is used for all terminally ill prisoners to ensure a multidisciplinary approach to managing prisoners at the end of their lives and to help continuity of care for those due to be released.
2. The Governor should ensure that wherever possible a Prison Service representative visits the next of kin in person to break the news of a death in custody.

ACTION PLAN: The Man – HMP Leeds

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that an end of life pathway is used for all terminally ill prisoners to ensure a multidisciplinary approach to managing prisoners at the end of their lives and to help continuity of care for those due to be released.	Accepted.	<p>An end of life pathway has been developed with the end of life team at Leeds Community Health based on guidance for prisoners.</p> <p>A full template is on system one with a register of any end of life patients ion the establishment.</p>	Complete	
2	The Governor should ensure that wherever possible a Prison Service representative visits the next of kin in person to break the news of a death in custody.	Accepted	<p>Every effort will be made to ensure that the news of a death in custody is given in person by a representative of the prison.</p> <p>Contingency plans updated</p>	Complete	