

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2013 at hospital,
while in the custody of HMP Channings Wood**

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 in April 2013 of a man, a prisoner at HMP Channings Wood. He was 71 years old and had been suffering from cancer. I offer my condolences to his family and friends.

A clinical reviewer reviewed the standard of healthcare the man received at the prison.

In October 2011, the man was referred for a scan which identified he had cancer of the oesophagus. He received chemotherapy treatment and in September 2012 had an operation to remove the cancer. Initially he made good progress, but in April 2013 his condition suddenly deteriorated. He was admitted to hospital on 3 April and tests showed his cancer had spread. He then transferred to another hospital, from where he was discharged back to Channings Wood on 17 April, although the prison had warned the hospital that they did not have 24 hour healthcare. He returned to hospital the same day after it was recognised that his condition was worse than the hospital had assessed and the prison was unable to provide the care he needed. His condition deteriorated rapidly before alternative arrangements could be made and he died in hospital at the end of April.

There was a delay of several days before the hospital processed the urgent referral when cancer was first suspected, this did not affect the man's diagnosis or treatment and I am satisfied that he received good care at Channings Wood. The decision by the hospital to discharge him, apparently prematurely, is outside the remit of this investigation, but indicates a need for the prison to plan more effectively for the ongoing care of severely ill prisoners after they are discharged from hospital.

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.

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Prisons and Probation Ombudsman

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SUMMARY

1. On 20 July 1966, the man was sentenced to life imprisonment for manslaughter and sexual offences. He was released on licence in 1980, but was recalled to prison in 1985 after another offence. He spent time in a number of prisons before his move to Channings Wood.
2. The man had a history of heart disease, was prescribed medication for rheumatoid arthritis and was monitored for seasonal asthma. In September 2011, he complained of indigestion and when medication did not ease the symptoms he was referred for an urgent scan in October, which identified cancer of the oesophagus. In March 2012, he started chemotherapy treatment and in September 2012 he had an operation to remove the cancer.
3. Despite initially responding well to treatment, in April 2013 the man's condition deteriorated. On 3 April, he was taken by emergency ambulance to hospital. He was told that his cancer had spread, and that treatment was not a viable option. He transferred to another hospital on 13 April. Channings Wood recognised that they would not be able to care for him, and told hospital staff at both hospitals that he would have to go to a different prison as they did not have 24 hour healthcare cover. Nevertheless, he was discharged on 17 April, only to be readmitted the same day as he was too poorly to be cared for at Channings Wood. While the prison continued to explore alternative arrangements with nearby prisons with inpatient facilities, his condition deteriorated rapidly. He remained at hospital, where he died at the end of April.
4. In light of the clinical reviewer's findings, we are satisfied that the man received a satisfactory level of care at Channings Wood. While the decision to discharge from hospital is outside the remit of the investigation, we have recommended better communications and care planning between the local hospital and Channings Wood before a prisoner is discharged.

THE INVESTIGATION PROCESS

5. The investigator issued notices informing staff and prisoners at HMP Channings Wood of the investigation and asking anyone with relevant information to contact her. No one responded.
6. The investigator visited Channings Wood on 9 May 2013. She met the Governor and obtained copies of the man's medical and prison records. She visited the wing where he had lived, and the healthcare unit. She spoke to staff who had known him.
7. The NHS appointed a clinical reviewer to review the man's clinical care at the prison.
8. The investigator gave her initial findings to the Governor during the investigation followed up in writing on 25 June.
9. The investigator informed HM Coroner for Torbay and South Devon about the investigation. The Coroner has been sent a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's next of kin on 14 May to explain the purpose of the investigation. She asked why he had been discharged back to Channings Wood on 17 April, only to be readmitted to hospital the same day.
11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his next of kin, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
12. As part of the consultation period the man's next of kin and Channings Wood received a copy of the draft report. The next of kin raised a number of points that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. Channings Wood identified an inaccuracy, and stated that the urgent referral made by a doctor on 21 October 2011, had been sent the same day to the hospital and was not delayed (which had resulted in a recommendation). The investigator liaised with the clinical reviewer and the hospital and, as a result, the report has been amended and the recommendation removed.

HMP CHANNINGS WOOD

13. HMP Channings Wood is a category C training prison near Newton Abbott in Devon. It holds over 700 convicted adult prisoners.
14. Health services at HMP Channings Wood were provided by the Devon Partnership Trust. From 1 April 2013, the service has been delivered by Dorset NHS University Trust. There is no inpatient unit. Nurses are on duty every day. An out of hours GP service is provided by a consortia of GPs commissioned by Dorset NHS.

HM Inspectorate of Prisons

15. The last report published on Channings Wood was an announced full inspection between 17 September and 21 September 2012. The report noted that the prison continued to perform reasonably well and the provision of healthcare was satisfactory, but had been disrupted by the absence of a healthcare manager and staff vacancies. Access to nurses and the GP was judged to be reasonable.

Independent Monitoring Board (IMB) report

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. The last available IMB annual report for 2011/12, noted that there has been deterioration in the overall performance of the healthcare unit. The IMB concluded:

“The unfamiliarity of temporary medical and nursing staff with both prisoners and prison systems has resulted, in our view, in a failure of prisoners’ rights (i.e. their right to receive a standard of medical care commensurate with that received by the wider community). Additionally, it is the belief of the Board that long term medical care, particularly of prisoners presenting with chronic conditions, can slip under the radar as a result of the above problems.”

Previous deaths at Channings Wood

17. The man’s death was one of six deaths from natural causes at Channings Wood in the past year. There are no direct similarities with the circumstances of the other cases.

ISSUES

18. The man had a history of childhood epilepsy, asthma (which was seasonal and regularly checked) and rheumatoid arthritis for which he was prescribed medication. His arthritis was regularly reviewed at hospital and he had blood tests in prison to monitor the impact of his medication. He had a history of ischaemic heart disease (furring up of the arteries that supply blood to the heart muscle) and had had a previous heart attack. He was not taking any medication for heart disease. He was a smoker but used lozenges (provided by the smoking cessation team) to help him stop.

The diagnosis of the man's terminal illness

19. The man suffered from indigestion over a number of years and was prescribed medication (gaviscon) to combat the symptoms. In September 2011, his indigestion symptoms increased in frequency. A doctor examined him on 16 September and diagnosed acid reflux when acid from the stomach leaks up into the oesophagus, (food pipe) and prescribed proton pump inhibitor medication to suppress acid production in the stomach. The monthly blood tests he had to monitor the affects of his arthritis medication indicated no concerns. (One of the indicators checked could have indicated that he had cancer.) There was no record of weight or blood loss.
20. On Friday 21 October 2011, the man said that he had difficulty swallowing. A doctor referred him for an urgent endoscopy under the NHS two week target for those suspected of having cancer. The medical records appear to show that he was referred four days after he actually was. The investigator verified with the hospital that the referral was faxed the same day, although was not processed as it should have been by the hospital. The clinical reviewer notified the Medical Director of the delay and he is to review the hospital's internal processes.
21. On 9 November, the man had an endoscopy and was diagnosed with adenocarcinoma (cancer) of the oesophagus.
22. The clinical reviewer comments:

“On current Department of Health guidance, the man should have been seen within two weeks of the decision to refer him for an opinion. He was referred on the same day the decision to refer was made. He was not seen within two weeks of the referral, as he should have been. The delay in him being seen appears to have been caused by a fault in the processing of the referral by SDHCFT [South Devon Healthcare Trust]. I do not believe, however, that this affected the ultimate outcome in his case, or reduced his chance of cure.”

Informing the man about his condition and treatment

23. The man was told about his diagnosis in November 2011, and that his condition was terminal, although not immediately life threatening. Medical records demonstrated good communication between the hospital and prison healthcare staff. He was able to make decisions about his treatment options and, with the support of mental health advisors, opted for surgery.

24. The clinical reviewer notes:

“There is excellent recording of information being given to the patient [the man] about diagnosis and treatment. There is detailed information in his healthcare record of information flowing from the multidisciplinary team to the healthcare staff, and of that information being passed to him ... There is evidence in the record that health staff not only gave him adequate information to make decisions about his own care, but that they sought outside assistance where they were unsure how to proceed. For example, he was clearly concerned that surgery would not increase his chance of survival, and staff brought in mental health advice to assist him in making the decision”.

25. We agree with the clinical reviewer and are satisfied that the man was appropriately informed about his condition, and was able to make informed decisions about his treatment.

The man’s medical appointments and treatment

Appointments

26. The man attended all medical appointments and there is no evidence that any were cancelled or re-scheduled.

Treatment

27. After his diagnosis, the man was assessed by a hospital multidisciplinary upper gastrointestinal cancer team. He underwent three cycles of chemotherapy which started on 9 March 2012 and ended in late April.

28. When the man’s condition was stabilised, he opted for surgery. On 10 September 2012, he had a procedure known as an Ivor Lewis oesophagectomy (removal of the oesophagus and part of the stomach). After the surgery, it took some time for him to adjust but, with the assistance of healthcare staff, once he had understood what dietary requirements were most appropriate, he managed well.

29. On 3 April 2013, the man’s condition suddenly deteriorated and he was admitted to hospital as an emergency. He was diagnosed with clots in the lungs (pulmonary embolus) and his cancer had spread. His treatment then became palliative rather than curative and he was told that he would not live much longer.

30. The man's treatment options following his final admission to hospital were limited to managing his condition, rather than curing his underlying illness. The clinical reviewer concludes that his treatment at Channings Wood was equivalent to that he could have expected in the community and his treatment was appropriate.

Palliative care

31. Once it becomes evident that a serious medical condition will not be responsive to treatment, it is usually appropriate that a palliative care plan is put into place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. The purpose of an end of life care plan is to help carers to plan when and how care will be delivered and to help the patient make choices about how they are cared for towards the end of their life.
32. The prison did not implement an end of life plan for the man as his condition was not regarded as terminal until his admission to hospital on 3 April. He decided to sign a do not resuscitate order (in the event of a cardiac arrest) on 4 April. On 26 April, the hospital began a formal end of life care plan, the Liverpool Care Pathway, to provide suitable care for the last days and hours of life. He died at the end of April.
33. We are satisfied that healthcare staff at the prison provided a good standard of care, with attention to the man's needs when he was at Channings Wood. The clinical reviewer was satisfied that the hospital implemented an appropriate end of life care plan.

The man's pain relief and medication

34. The man was prescribed medication as directed by the hospital consultant. When he was at Channings Wood healthcare staff regularly reviewed his care plan. He did not require significant pain relief medication until his final admission to hospital. The clinical reviewer has noted that when he entered the end stage of his illness, a syringe driver was used to administer pain relief medication.
35. In light of the clinical reviewer's comments, we conclude that the man's medication and pain relief was managed appropriately.

The man's location

36. The man continued to live in his usual accommodation at Channings Wood after his diagnosis. When his condition deteriorated on 3 April he was admitted to hospital and on 13 April moved to another hospital (a GP led in-patient ward primarily for patients who need rehabilitation or medical assessment). Although prison healthcare staff told the hospital that he would need to have a planned discharge as they did not have 24 hour healthcare cover, they discharged him back to Channings Wood on 17 April. Prison escort staff were so concerned about his condition that they alerted a nurse immediately they arrived back at the prison, and she went to see him while he was still in the car. The nurse discussed her concerns with the deputy manager of healthcare and a doctor. They immediately contacted the hospital to inform them that he was too unwell to be discharged to Channings Wood. He was then taken back to the hospital.
37. The deputy manager of healthcare at Channings Wood submitted her concerns in writing to the University NHS Foundation Trust (Dorset Healthcare) regarding the man's discharge and the inaccuracy of the hospital's assessment of his condition and ability to look after himself. In response to this letter, the Assistant Director of Community Hospitals accepted that his condition should have been communicated more accurately, and said that processes had been reviewed as a result of the complaint.
38. The clinical reviewer has noted that hospital staff did not fully understand that Channings Wood could not provide the care that the man needed. He agreed that it was appropriate for him to return to hospital and comparable to what would have happened in the community. The clinical reviewer goes on to say:

“Planning for end of life care is an important strand of health planning... the provision of ‘hospice at home’ care will present particular challenges to the prison service... The prison population is growing older with the general population, and the health service is increasingly looking to community provision of end of life care, as close to the patient’s home as is possible... the healthcare provider may wish to consider how it will position itself to provide ‘hospice at home’ style of care rapidly, to meet individual circumstances, in the future. With the pressure on hospitals to turn patients around quickly, prison care will have to learn how to be more responsive.”
39. We agree that Channings Wood will need to consider how to provide appropriate social care for those who need it, but in this case the man's needs had not been assessed appropriately by the hospital before his discharge. Channings Wood reacted promptly when they recognised that they were not able to meet his care needs. The prison had considered transferring him to a prison that had inpatient and social care facilities (HMP Exeter) but arrangements had not been put in place before his unexpectedly rapid decline.

40. We conclude that the man's location on his unit at Channings Wood, until his decline in April, was appropriate. The clinical reviewer was concerned about the circumstances of his discharge from hospital, but was satisfied that his care was not affected by these events. The decision by the hospital to discharge him is not within the remit of this investigation. However, it is apparent that he needed regular nursing care and monitoring that was not available in Channings Wood. Such arrangements might have been made if there had been more time to arrange a transfer to HMP Exeter or another prison. While it does not appear in this case that he should have been discharged at the time he was, we consider there is a need for a clear process to identify the most suitable location for a seriously ill prisoner to ensure appropriate care is provided when it is established that hospital care is no longer necessary.

The Governor and Head of Healthcare should liaise with local hospitals to agree effective ongoing care plans for seriously ill prisoners to ensure that the Prison Service can meet their health and social care needs when they are ready for discharge from hospital.

Compassionate release

41. Release on compassionate grounds is a means by which prisoners who are seriously ill (generally with a life expectancy of less than three months) can be released from custody. The man's condition worsened on 18 April 2013. A doctor completed a medical report for compassionate release the same day, stating he had a life expectancy of between two and three months. Other relevant information about his situation was collated. He had no release address or family support, but said he wanted to go to a hospice. The Governor considered the application on 24 April 2013. He supported release at the point his physical condition required hospice care and all information was submitted to the Public Protect Casework Section (PPCS) at the National Offender Management Service (NOMS).
42. We are satisfied that at the point the man entered the end stage of his illness Channings Wood submitted a timely application for compassionate release to a hospice. Unfortunately, due to the rapid decline in his condition, the application was not able to be considered before he died.

Liaison with the man's next of kin

43. The man had little contact with his family and had nominated a friend as his next of kin. A residential manager informed his friend when he was admitted to hospital on 3 April, and a prison family liaison officer was appointed the next day. One of the prison chaplains discussed with his friend whether his family should be notified of his situation. His friend contacted the family and kept them updated as they did not want direct contact from the prison. The prison told the man that he could use the prison escort mobile telephone to contact his friend each day if he wished. On 26 April, his friend visited him at hospital. She requested that she should be contacted by telephone, but not during the night, if he died.

44. The duty governor notified the man's friend of his death by telephone, in line with her wishes. Channings Wood ensured all his property was returned and, in line with national policy, funeral expenses were paid.

Restraints and security

45. 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.
46. After his initial diagnosis in November 2011, the man was subject to a two officer escort and restrained with an escort chain (a two metre long chain with a cuff at either end) when attending outside hospital, which was removed when he was receiving treatment. Each time he was taken to hospital, the risk assessment was reviewed and medical opinion was sought. On 5 July 2012, during an appointment with a female nurse, he became very aggressive and the appointment was terminated. Although this did not alter the level of escort and type of restraint, the risk assessment noted there should always be at least one male officer present when he was taken out of the prison. His condition did not restrict his mobility and there is evidence that his behaviour continued to be threatening particularly towards female staff.
47. On 3 April 2013, when the man was taken to hospital, the escort risk assessment was reviewed. The duty governor authorised a two officer escort, but concluded that restraints were not necessary. Restraints were not used again.
48. We acknowledge that public protection is paramount and security measures must be proportionate to a prisoner's individual circumstances. While he was an elderly man, he continued to indicate he was a risk to the public. On his final admission to hospital account was taken of his medical condition and the risk assessment was altered accordingly. The duty governor authorised that restraints were not necessary and they were never reapplied. We are satisfied that appropriate decisions were taken about the risk of restraints.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should liaise with local hospitals to agree effective ongoing care plans for seriously ill prisoners to ensure that the Prison Service can meet their health and social care needs when they are ready for discharge from hospital.

Accepted: *Contact will be made with the Discharge Liaison team at the hospital to work on an acceptable protocol which ensures that prisoners' needs are discussed with the prison healthcare team prior to discharge from hospital.*

Prison staff (detail office / orderly officer - outside of normal working hours) will inform healthcare as soon as they are aware that a prisoner is returning to the prison from hospital.

In order to improve communications between escorting staff and healthcare, a written protocol / guidance document for escorting staff or a Governor's Order will be introduced to ensure that a prisoner's holistic needs are considered and met prior to discharge from hospital.

More widely, in conjunction with NHS England, relationships continue to be developed between the local County Council and the Devon cluster of prisons to enhance access to assessment and support services for prisoners with social care needs. The Care Bill which is currently in Parliament is expected to clarify responsibility for the Local Authority to assess social care needs of prisoners and provide services to meet eligible needs. Target date for completion: 30 November 2013