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 in May 2013 at HMP Preston.

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 at HMP Preston in May 2013. He died of bronchopneumonia, caused by metastatic carcinoma of the rectum. He was 66 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a review of the man's clinical care whilst in custody. Preston and Risley co-operated fully with the investigation.

The man was diagnosed with a return of colorectal cancer in November 2012, shortly after he was sent to prison. He was diagnosed quickly and had some treatment in hospital, but was mostly treated at Preston, where he moved so that he could be provided with inpatient treatment.

The clinical reviewer concludes that the man's care was at least equivalent to that which he could have expected in the community and I agree. In many respects he and his family were treated with commendable compassion, for which the family expressed appreciation. It is, therefore, disappointing to find that the use of restraints, when frail and immobile he attended hospital, was not always based on properly evidenced risk assessments.

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 **November 2013**

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SUMMARY

1. The man was born in 1946. In 2011 and 2012, he received treatment in the community for cancer. In June 2012, he was told he was in remission. In October 2012, he was given a six year sentence for historical sex offences. This was his first conviction and custodial sentence.

2. The man was initially sent to HMP Altcourse, before moving to HMP Risley at the beginning of November. He arrived in prison feeling poorly and received treatment from the prison doctors. In November 2012, he was sent to hospital where he had three operations: a laparotomy (a procedure for investigation of the body by cutting into the abdomen); a colostomy (an operation to let urine and stools out the body if going to the toilet is difficult); and a biopsy (taking out body tissue to examine it for a diagnosis).

3. The hospital told the man that the cancer had returned. He was discharged to the healthcare centre at HMP Preston, which was better able to deal with his healthcare needs. However, he remained a Risley prisoner. He had various hospital appointments as an outpatient and spent time in hospital as an inpatient.

4. When the man was given his diagnosis, he was told that it was unlikely he would recover unless very aggressive treatment was used, for which he needed to be stronger. In March 2013, doctors at hospital told him his cancer was terminal and curative treatment was not an option. He was given palliative care (to relieve his symptoms but not cure the disease) and received end of life care based on the Liverpool Care Pathway.

5. On 29 April 2013, the man married his long-term partner in the healthcare centre at HMP Preston. The ceremony was attended by staff and prisoners. After this, his health deteriorated quickly. He died of bronchopneumonia caused by metastatic carcinoma of the rectum in May 2013.

6. We are satisfied that the care and attention the man received was equivalent to or potentially exceeding that which he would have received in the community. However, we make a recommendation about the risk assessment process for the use of restraints to ensure the appropriate level of restraints is used.

THE INVESTIGATION PROCESS

7. This office was notified of the man's death on 8 May 2013. An investigator was appointed and she and contacted the prison, who sent documents relating to the man's time in prison. She visited HMP Preston with an Assistant Ombudsman on 6 June and viewed the health care centre. During the visit, they spoke to the health care manager, the Head of the Inpatient Unit and the Governor.

8. The local PCT commissioned a clinical reviewer to conduct a clinical review into the care provided for the man while he was at HMP Preston.

9. On 10 June, one of the Ombudsman's family liaison officers telephoned the man's wife, his nominated next of kin. She explained the purpose of the investigation. The man's wife said the family had no concerns about the clinical care her husband received at Preston and gave only praise for the care and liaison she and her husband received. Liaison with the family is discussed in more detail later in the report. The family received a copy of the draft report. They did not raise any issues that impact on the factual accuracy of this report.

10. 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.

HMP RISLEY

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

Her Majesty's Inspectorate of Prisons

12. HM Inspectorate of Prisons conducted a full announced inspection of Risley in February 2011. Inspectors commented that relationships between the prison and the NHS agencies were good and that there was an appropriate range of primary and life-long care. Macmillan nurses and hospice services helped provide individual care packages for patients in the end of life stages.

Independent Monitoring Board

13. 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 found facilities for disabled prisoners had been improved. A new model of GP Practice had been introduced which has significantly reduced the need for locum GPs. They hoped that this would improve the continuity of GP care.

HMP PRESTON

14. HMP Preston is a local prison holding up to 842 remanded, unsentenced and convicted adult male prisoners. Healthcare is provided by Lancashire Care Foundation Trust. The healthcare unit has inpatient facilities which are used as a regional facility for up to 30 prisoners with mental and physical health problems. There is a full-time doctor between 9.00am and 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area and at night and weekends there is on-call cover.

Previous deaths at Preston

15. There have been 11 deaths at Preston since 2010, six from natural causes**.** None of the circumstances of the previous investigations are similar to those in this case.

Her Majesty's Inspectorate of Prisons report

16. HM Inspectorate of Prisons made an unannounced short follow up inspection of Preston in April 2012. Inspectors noted that an appropriate range of health services were provided, primary care services had improved and inpatient services were satisfactory, with an improved regime for the prisoners there.

Independent Monitoring Board (IMB)

17. In Preston IMB's annual report covering the period 1 April 2011 to 31 March 2012, the IMB noted:

“Over the last 12 months we have had a number of ‘end of life’ patients who have been looked after on the healthcare facility in their final months of life and in two cases we have been commended for providing a service that is better than those which are available outside of the prison.”

ISSUES

The diagnosis of the man's terminal illness

18. When he arrived at HMP Altcourse on 26 October 2012, the man saw a nurse and was referred to the prison GP. He told the GP that he had seen a GP in the community the previous week because he had symptoms of sickness. He said he still felt poorly.

19. On 1 November, the doctor suspected the man might have an infection in his digestive system and admitted him to the in-patient unit at Altcourse. He stayed there until 5 November, when he returned to the wing. Over the next two weeks he was monitored by prison nurses and doctors who began tests to try and find the cause of his symptoms. On 9 November, he was transferred to HMP Risley. On 14 November he saw the GP, who again noted his symptoms, made a health plan and prescribed medication. The health plan included measures to make his bowel movements more regular and further plans if the initial laxatives did not work.

20. On 16 November, the man saw another GP complaining of increasing abdominal pain and decreased appetite. There were no escort staff to take him to hospital, so the doctor arranged an appointment with the hospital the next day. This did not cause a significant delay to his diagnosis. The doctor wanted to investigate whether his previous cancer had returned. He had a CT scan (a computerised tomography scan, which uses X-rays and a computer to make detailed images of the inside of the body) and an X-ray. The tests showed a bowel obstruction and a pelvic mass. On 17 November, it was confirmed that colorectal cancer had returned and spread to his liver. The hospital conducted a laparotomy, colostomy and a biopsy.

21. We are satisfied the diagnosis was completed appropriately and as soon as possible.

Informing the man about his condition and treatment

22. The man was given his diagnosis in hospital. As we do not have his hospital records, it is not clear how he was told about his illness and the effects it might have. However, a letter from the hospital to the prison on 18 December confirmed that there was only a miniscule chance of a cure, that he was aware of the diagnosis and wanted 'every necessary action to be taken' for the best possible result. Staff at Preston and the hospital put in place care plans and discussed treatment with him.

23. The man returned for further appointments after his initial stay in hospital. On 7 March, he was taken to hospital as an emergency and stayed overnight. The next day, doctors confirmed to him that the cancer had spread and told him that his illness was terminal.

24. When the man was next in hospital, as an inpatient from 22 March to 10 April, doctors told him that he would need to be stronger to have chemotherapy, but that this was unlikely to happen. He was told that he had four to six months left to live. It was noted that he was still hopeful he would become well enough for treatment.

25. On 16 April, the man saw a consultant in palliative medicine. He was told surgery was not possible and again that he was not fit enough for chemotherapy. On 24 April, healthcare staff completed the Preferred Priorities of Care document (a tool to discuss and record the individual's wishes, to form the basis for their future care) with him. In this meeting, they documented discussions that had taken place - with doctors, the hospice, healthcare staff, and his family - over the previous two weeks.

26. It is apparent that throughout his care, the man was fully informed of his diagnosis and treatment options. Healthcare staff regularly discussed future health plans and any hospital results with him and talked about the diagnosis to make sure he understood. The clinical reviewer notes that HMP Preston was pro-active and committed in getting his opinion and consent about his care.

The man's medical appointments and treatment of the prisoner

27. After his first stay in hospital, the man had further appointments scheduled. On 18 December, he had a follow up appointment at the oncology clinic. The hospital confirmed to him that his cancer had returned and only aggressive treatment was recommended. Palliative chemotherapy was recommended with treatment scheduled at Preston's inpatient unit. He then had a further cancer screening on 27 December, at hospital. A follow-up appointment on 2 April was cancelled as he was in hospital as an inpatient.

28. On 22 March, the man was taken to hospital for a pre-arranged blood transfusion. This had been arranged by the doctor at the prison; however the hospital staff who received him were not aware of the appointment. He was given a blood test and the hospital decided that he did not need a blood transfusion and discharged him back to Preston.

29. The man returned to hospital as an emergency on 24 March as he had frequent episodes of melena (black stools, which indicated internal bleeding). He remained in hospital until 10 April. While there, he had an oncology review and a urology consultation because he could not urinate. This resulted in a long-term catheter being inserted. He was diagnosed with gastrointestinal bleeding which meant that he could not be treated with steroids. Nodules in the lung were noted. The hospital provided a care plan for his return to Preston, which was followed.

30. The man was not able to receive the curative treatment that he wanted but he received daily care and his illness was well-managed. The prison liaised frequently and effectively with the hospital and kept up to date with his condition when he was an inpatient in hospital.

The man's pain relief and medication

31. When the man reported pain he was seen by a doctor and his prescription was reviewed and changed. The clinical reviewer notes that pain medication was patient-led and that breakthrough pain and symptom control were well managed by the prison, who followed NICE (National Institute for Health and

Care Excellence) guidelines. The consultant oncologist also gave advice about pain relief, which was implemented by the prison.

32. The man's medical notes show that healthcare staff were aware of his needs. They made sure in advance that end of life drugs were stocked and ready for use. Prescriptions were appropriate and pain was kept under control.

The man's location and early release on compassionate grounds

33. On 9 November, the man was transferred to Risley, where he was placed on a wing. He remained there until 17 November, when he transferred to hospital. On 30 November, he moved to the healthcare centre at Preston, considered the best place in prison to meet his needs.

34. Preston liaised with a hospice on 3 December 2012, to see if he could be cared for there when appropriate. They began to consider release on compassionate grounds on 11 December. 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. Staff at the prison discussed this with him, but he said that he would prefer to remain at Preston.

35. The man's location was considered in detail before and very soon after the diagnosis of his cancer. He preferred to remain in Preston. We consider that he was in the best location for his situation and that Preston considered other possibilities at the earliest opportunity.

Liaison with the man's family

36. When the man became very sick, it was agreed that his partner and brother could come to the healthcare centre on a compassionate visit on 18 April. A family liaison officer (FLO) was appointed at this time and met them on this visit. A nurse talked to them about the Liverpool Care Pathway and the DNAR (Do Not Attempt Resuscitation order), which had been discussed with him the day before. Nurses also told them about his future pain relief options and gave them general information about his condition.

37. When the man was too ill to move far, his partner was able to visit at the healthcare centre where, on 29 April, they married. When he died, the FLO and two chaplaincy staff visited his partner at their home to break the news of his death. The prison contributed towards the costs for the funeral, in line with national guidance.

38. The man's family stated that they were very happy with the way the prison treated them and the information that they received about him. His partner sent thank you cards to the prison.

Palliative care plans

39. Palliative care plans were led by the prison, although there was consultation with the hospital. Before his discharge from hospital, staff decided that he would undergo palliative chemotherapy in Preston, which was the best place to serve his needs. The end of life care plan was therefore implemented

before the terminal stages of the illness. The prison was able to stock the end of life care drugs for easy access, in line with the care plan, which was regularly reviewed.

40. On 17 April, the man signed a DNAR (Do Not Attempt Resuscitation order, meaning that hospital or prison staff would not attempt to resuscitate him were his heart to stop beating). The prison doctor and a nurse noted in his medical record that this was open to discussion and review, should he change his mind.

41. When the man approached the end of his life, a syringe driver (a small, portable pump that gives a continuous dose of medication or pain relief through a tube inserted just under the skin) was obtained in advance. Training in operating the syringe driver was delivered to staff on 2 May. This was planned in advance and given due consideration.

42. On 2 May, the syringe driver was started to give the man 24 hour pain relief, after he gave his consent. The Liverpool Care Pathway was put in place on 3 May, with the consent of his wife. He was not conscious by this time and could not make the decision himself.

Restraints, security and bed watch

43. 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. 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 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 also to be regarded as inhumane unless justified by other relevant considerations.

44. On 7 March, the man was taken to hospital as an emergency in an ambulance. Two officers were present and handcuffs (one cuff is attached to the prisoner and the other to the escorting officer) were authorised. At hospital, an escort chain (a long chain with a cuff at either end) was used. On his return to prison, he was double cuffed (one set of cuffs is applied to the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other to one of the escorting officers).

45. The next day, it was noted in the escort record that the escorting officer asked the doctor whether the restraints should be removed while the man had a CT scan. The doctor said it was not necessary. The escort staff wore lead aprons and stayed behind screens during the scan. Given his condition at the time (he had been described as "frail and weak" the day before) there seems

little reason why authority could not have been given for restraints to be removed during treatment.

46. The man was 'weak and frail' on 20 March and was attending hospital for a blood transfusion as he was very unwell. On 22 March, when he was again taken to hospital, he was assessed as a medium risk to the public and staff and had the ability to escape. He was taken out in a wheelchair with two officers and single handcuffs. The medical assessment was completed but was brief, stating that he had the ability to escape. It did not take his current state of health into account.

47. We are not convinced that the risk assessments justifying the use restraints on the man reflected the actual risks posed. We consider there is a need for all those involved in making decisions, including healthcare staff, to familiarise themselves with the principles of the High Court judgement which were circulated to all prisons after the case and reiterated last year as a result of concerns from this office. We make the following recommendation.

The Governors of Preston and Risley should ensure that the use of restraints for hospital escorts reflects the prisoner's actual risk at the time, and that information from healthcare and from previous escorts should help inform this decision.

RECOMMENDATIONS

1. **The Governor should ensure that the use of restraints for hospital escorts reflects the prisoner's actual risk at the time, and that information from healthcare and from previous escorts should help inform this decision.**

PRISONS AND PROBATION OMBUDSMAN for England and Wales

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ACTION PLAN: The Man – HMP Preston and Risley

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that the use of restraints for hospital escorts reflects the prisoner's actual risk at the time, and that information from healthcare and from previous escorts should help inform this decision.	Accepted	Risk assessments at both prisons have now been amended and an option included for managers to consider no restraints. In addition, following a review, a new version of the risk assessment which flows better has been drafted and is awaiting approval. This will further ensure that managers have all the necessary information to make an informed decision about the level of restraint to use. This will include information from healthcare and from previous escorts. All managers will be reminded that when considering cuffing arrangements they must be proportionate to the risks posed by the individual prisoner, having full regard to a prisoner's clinical condition at the actual time. The risk assessment must also be regularly reviewed to take account of the prisoner's changing circumstances.	30 September 2013	