



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man while a prisoner
at HMP Stafford on 19 February 2014**

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, who died of bladder cancer on 19 February 2014, while a prisoner at HMP Stafford. He was 72 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was sentenced to 12 years and six months in prison in November 2011 and transferred to HMP Stafford in August 2012. He did not have much interaction with healthcare staff until November 2013 when his cellmate and an officer on his wing became concerned about his health. The doctor suspected the man had cancer and made an urgent referral to a hospital specialist. The man was unable to attend the appointment because there were no officers available to escort him. The appointment was rearranged for over a week later. On 30 December, he was taken to hospital as an emergency and was found to have a tumour on his bladder.

The man had an operation to remove the tumour and received treatment in hospital. The hospital wanted to discharge him back to prison on 13 January, but he needed 24 hour care which HMP Stafford could not provide. A place could not be found in other prisons with full time healthcare facilities and, when the hospital discharged him on 24 January 2014, he went back to Stafford. His health deteriorated quickly and he returned to hospital three days later. On 1 February, he was moved to a hospice where he remained until he died.

The clinical reviewer found that the care the man received was equivalent to that he might have expected in the community. However, I share his concern that Stafford did not have the appropriate facilities or staffing to care for such a sick man after he was discharged from hospital. It is also unsatisfactory that he was unable to attend his urgent referral appointment when doctors first suspected cancer. Finally, I am concerned that the use of restraints when he was in hospital was not justified by a fully considered risk assessment.

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 serving a 12 years and six months sentence for sexual offences and had been at HMP Stafford since August 2012. He had little interaction with healthcare staff until 2 November 2013, when his cell mate reported to officers that there was blood in the toilet area of the cell. A nurse went to see him but the man denied he had any health issues. A prison doctor assessed him on 4 November and referred him urgently to hospital to check for cancer.
2. The man missed a hospital appointment on 19 November because an escort was not available. He appears to have gone to a re-arranged hospital appointment later in November, but refused to attend a further appointment on 19 December. On 30 December, a nurse saw the man in his cell after officers reported he was very ill and he was taken to hospital.
3. At hospital, tests indicated that the man had a tumour on his bladder and on 3 January he had had an operation to remove the tumour. It is not clear what diagnosis hospital doctors gave him at the time, although the clinical reviewer notes the seriousness of his condition must have been explained before the operation. The hospital was prepared to discharge the man on 13 January, but said he needed 24 hour care. As HMP Stafford does not have 24 hour healthcare, the healthcare team leader attempted to find the man a place at another suitable prison. Although there is a protocol between prisons in the area to provide 24 hour healthcare facilities when required, a place could not be found.
4. The hospital discharged the man on 24 January and now said he did not need 24 hour care. The clinical reviewer noted that there was evidence to the contrary. There were some difficulties caring for him at night and, because he was very unwell, he was readmitted to hospital on 27 January. The next day, a specialist in the hospital informed healthcare staff at Stafford that the man had advanced bladder cancer and needed supportive care. On 1 February, he was transferred to a hospice and remained there until he died.
5. The clinical reviewer was satisfied that the overall care the man received was equivalent to that he could have expected in the community. However, his location at Stafford was unsuitable after he was discharged from hospital and there is a need to ensure that there are adequate arrangements to provide pain relief for seriously ill prisoners. The use of restraints when he went to hospital was not justified by a fully considered risk assessment. We make four recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She gave the Governor initial feedback on the preliminary findings of the investigation in writing.
8. NHS England commissioned a doctor to review the man's clinical care at the prison.
9. We informed HM Coroner for South Staffordshire District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
10. One of the Ombudsman's family liaison officers contacted the man's wife, his nominated next of kin, to explain the investigation. His wife had no specific concerns for the investigation to consider.
11. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital appointments, liaison with his family and whether compassionate release was considered
12. The man's family were informed the draft report was available, but did not wish to receive a copy or make any comment. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP STAFFORD

13. HMP Stafford is a category C training prison which holds more than 700 prisoners across seven wings. Staffordshire and Stoke-on-Trent Partnership NHS Trust provide healthcare. There are no inpatient facilities. Nurses and doctors provide care daily between 8.00am and 5.00pm. There is an on call service, for doctors outside these hours.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Stafford was in July 2011. The Inspectorate found that there was no specific policy for older prisoners or those with disabilities. Adjustments were made to help those with disabilities, but they were not consulted about them. The relationship between prisoners and health service staff and the management of lifelong conditions were both regarded as excellent.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to April 2103, the IMB commented that staffing escorts and bed watches for prisoners attending appointments or staying in hospitals could be problematic.

Previous deaths at HMP Stafford

16. The man was the third prisoner to die of natural causes at HMP Stafford since January 2012. There are no similarities between the circumstances of his death and the other cases.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

17. The man was serving a 12 and a half years sentence for sexual offences and had been at HMP Stafford since 30 August 2012. He did not report any serious health problems when he arrived.
18. On 2 November 2013, a nurse went to see the man after his cellmate had reported blood in and around the cell toilet. The man said he had no health problems. A doctor saw the man on 4 November and the man told him that there had been blood in his urine for a few weeks. The doctor noted that he had lost weight and made an urgent referral to a urology specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
19. The man was unable to attend a hospital appointment on 19 November, because the prison had no staff escorts available as another prisoner had been taken to hospital as an unexpected emergency. The doctor rebooked the appointment for 28 November. There is no record that the man attended this appointment, but healthcare staff assure us he did. He declined to attend a further appointment on 19 December and signed a disclaimer to this effect.
20. On 30 December, a nurse went to see the man and noted that he seemed very unwell. He had lost weight and there was blood on his clothes. She took his clinical observations and found he had low blood pressure and a rapid pulse. She gave him oxygen and called an ambulance. The man was taken to University Hospital North Staffordshire. He had a blood transfusion and a CT scan which showed a tumour in his bladder. He remained in hospital and, on 3 January, he had an operation to remove the tumour. The clinical reviewer says that the hospital medical records do not make it clear what hospital staff told the man about his condition but notes that, given the pre-operative findings, doctors would have needed to explain to him the seriousness of his condition as part of the process of getting his consent to the operation.
21. The man was discharged to Stafford on 24 January. Hospital staff had told him that he had suspected bladder cancer, but this could not be confirmed until the results of further tests were received. He was admitted to Mid-Staffordshire Hospital, on 27 January when he was unwell and healthcare staff at the prison noted he had still not received a formal diagnosis. The next day, University Hospital North Staffordshire, which analysed the test results, confirmed that he had cancer at an advanced stage and no active treatment was possible.
22. The hospital diagnosed and informed the man of his condition, although was not initially able to let him know the extent of his condition until further tests. After healthcare staff at Stafford expressed concern about the man's health we are satisfied that the doctor appropriately referred him to hospital urgently

with suspected cancer on 4 November. The NHS has a target for such urgent referrals to be seen within two weeks. An appointment was made for 19 November, just outside this target. Although there is no evidence that this affected the outcome for the man, we are concerned that he missed such an important appointment because of a lack of prison staff to escort him. We were told that there was an emergency admission to hospital that day, but his appointment should also have been prioritised. The cancellation by the prison meant he did not have his urgent appointment until three and a half weeks after the referral. We make the following recommendation:

The Governor should ensure that prisoners are taken to all urgent hospital appointments unless there are overriding fully justified and documented reasons and there is no detriment to the prisoner's health

The man's medical treatment

23. The man continued to be cared for in hospital until he was discharged on 24 January. No active treatment was planned. He was prescribed paracetamol for pain relief and the hospital recommended 1 gram as required, usually three to four times daily.
24. The clinical reviewer notes that a nurse kept detailed clinical records which indicate that the man received a good standard of nursing care at Stafford within the confines of the prison regime. When he returned from hospital on the evening of 24 January, the nurse had left a sealed letter in his cell for officers to give to an out of hours response doctor or paramedics if they were called during the night, which detailed his illness and current care needs.
25. In the early evening of 26 January, the nurse recorded that the man said that he had been reluctant to report being in pain in hospital and that he had been suffering pain for a couple of weeks. The nurse assessed that his pain relief was inadequate and noted that this would be reviewed the next day. The next day, this was not reassessed at the prison as he was admitted to hospital.
26. After 27 January, the man's care was in hospital. He was referred to a palliative care nurse on 31 January and moved to St Katharine House Hospice, Stafford on 1 February. At the hospice, he received morphine pain relief and the clinical reviewer notes that his wellbeing and appetite appears to have improved. He remained comfortable and pain free until his condition deteriorated quickly. He died at the hospice on 19 February. The Coroner gave the cause of death as metastatic bladder cancer.
27. While we do not consider that HMP Stafford was an appropriate place to care for the man (see location section below), we are satisfied that his nursing care at the prison was good. However, the clinical reviewer notes that on the evening of 26 January, when the man complained of pain, no effective alternative appeared to be available. We make the following recommendation:

The Head of Healthcare should ensure that there are arrangements to allow prisoners who are seriously ill access to appropriate levels of pain relief at all times.

The man's location

28. Most of the man's care after his illness was diagnosed was in hospital and then at the hospice where he died. However, we are concerned that he was discharged to Stafford on 24 January, which did not have the facilities to care for him. He returned to hospital on 27 January.
29. Stafford does not have 24 hour health care and there are only two trained nurses on duty during the day. In the National Offender Management Service West Midlands area, there are three prisons which have an inpatient unit, Dovegate, Birmingham and Hewell. These prisons are expected to provide a regional service for the other prisons which do not. They take prisoners in need of 24 hour care on a rota basis and this is coordinated by the local NHS Area Team.
30. Originally when the hospital wanted to discharge the man on 13 January, they told the healthcare manager that he needed 24 hour care. Stafford could not provide this and neither Dovegate nor Birmingham would accept him. (Hewell was full at this time). Dovegate said they had no places for vulnerable prisoners and Birmingham said they had checked with the hospital who said that the man did not need 24 hour care. Healthcare staff from Birmingham did not assess him themselves as they had said they would. However, on the instructions of the NHS Head of Offender Health, he went back to Stafford as the hospital now said he did not need it.
31. Healthcare staff and officers at Stafford appear to have done their best to look after the man. However he was difficult to manage and on the first night back at the prison he disconnected his catheter bag during the night, which resulted in a spillage of blood stained urine. Officers were not prepared or trained to intervene and the out of hours doctors service said they could not help. (A nurse said they had helped with catheter issues before.) The man remained without a catheter and in a soiled bed until the morning, when healthcare staff came back on duty.
32. The clinical reviewer says the man should have been assessed by one of the prison 24 hour care units before he was discharged from hospital, and that Stafford was unsuitable for his needs. We agree and consider that it was not acceptable that he should have been discharged to unsuitable accommodation without appropriate full time care facilities, whether or not this was nurse led care. A more effective assessment and discharge protocol would have helped avoid this. The healthcare manager submitted a critical incident form to the NHS Stafford and Stoke on Trent Partnership Trust to highlight the problems with the man's discharge and we understand that it is intended that the current protocol will be reviewed. We make the following recommendation:

The Head of Commissioning, NHS Area Team West Midlands, should implement an effective protocol to ensure that seriously ill prisoners are located where they have appropriate care to meet their needs.

Restraints, security and escorts

33. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of 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.
34. On 30 December, the man went to hospital and was restrained by a single handcuff on the journey and an escort chain once he arrived. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) A nurse signed the medical section of the assessment saying there was no medical reason restraints could not be applied but there was no healthcare input to say whether his condition impacted on his risk of escape, as required by the 2007 High Court Judgement. On 3 January, officers removed restraints for the man's operation and reapplied them again afterward. He remained in restraints until 21 January, when the restraints were permanently removed, after a further risk assessment.
35. There is no evidence that the man's risk was re-assessed before 21 January, and no evidence that there was any healthcare input regarding his condition or its impact on his risk of escape. There are notes throughout the escort log which show officers adjusted his restraints frequently because they were causing discomfort or for medical reasons.
36. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. The man was frail, not very mobile and extremely ill for most of the time after 30 December 2013. We are not satisfied that restraints were justified by fully considered risk assessments that took into account his risk and condition at the time. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

Liaison with the man's family

37. Initially, the man did not want his family informed of his illness. However as he became increasingly ill he changed his mind, and a prison family liaison officer informed the man's family on 3 February.
38. On 16 February, when his condition deteriorated the family liaison officer contacted the man's family to inform them. He arranged for them to visit the man if they wanted but his family decided not to.
39. After he died, the family liaison officer telephoned his wife (as he had agreed with her in advance) to inform her. He arranged to visit her at her home. The prison contributed towards the funeral expenses in line with national guidelines. His funeral was on 5 March and representatives from the prison attended.

Compassionate release

40. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
41. Records show that prison staff began the process on 31 January and the man's consultant at the hospital was asked to complete the medical section of the form. We could find no evidence of any response or that this was followed up. However, it is unlikely that compassionate release would have been agreed because his did not have a clear prognosis at the time and no agreed release address.

RECOMMENDATIONS

1. The Governor should ensure that prisoners are taken to all urgent hospital appointments unless there are overriding fully justified and documented reasons and there is no detriment to the prisoner's health
2. The Head of Healthcare should ensure that there are arrangements to allow prisoners who are seriously ill access to appropriate levels of pain relief at all times.
3. The Head of Commissioning, NHS Area Team West Midlands, should implement an effective protocol to ensure that seriously ill prisoners are located where they have appropriate care to meet their needs.
4. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

ACTION PLAN: A man – HMP Stafford

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that prisoners are taken to all urgent hospital appointments unless there are overriding fully justified and documented reasons and there is no detriment to the prisoner's health.	Accepted	<p>The Governor will prioritise resources to ensure urgent medical cases or appointments are kept and cancellations minimised. An instruction has been issued to all operational managers advising them to refer any resource issues to the Deputy Governor or Governor in charge.</p> <p>The Governor has submitted a business case for additional resources to meet the demands for escorted healthcare appointments.</p>	<p>Deputy Governor</p> <p>31 August 2014</p>
2	The Head of Healthcare should ensure that there are arrangements to allow prisoners who are seriously ill access to appropriate levels of pain relief at all times.	Accepted	<p>There are existing arrangements in place for healthcare staff to access pain relief for patients who require it. This is via a GP between 08:00-18:30 Monday to Friday, and the out of hours GP outside of these times.</p> <p>Staff have been reminded of these arrangements both verbally and by email.</p>	<p>Head of Healthcare</p> <p>Completed and ongoing</p>
3	The Head of Commissioning, NHS Area Team West Midlands, should implement an effective protocol to ensure that seriously ill prisoners are located where they have appropriate care to meet their needs.	Accepted	<p>NHS England will review and clarify the current West Midlands Medical Transfer Protocol with healthcare providers.</p> <p>The Shropshire and Staffordshire Area Team are supporting a Regional Inpatient Review to clarify the location and role of prison inpatient units and suitable admission criteria.</p>	<p>NHS England</p> <p>30 September 2014</p> <p>30 April 2015</p>

4	<p>The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand that legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.</p>	Accepted	<p>In line with national guidance, healthcare staff now provide more detailed information about each prisoner's mobility and other relevant health factors when risk assessments are completed before they are taken to hospital.</p> <p>The risk assessment documentation for all bedwatches will be redesigned to include a review of restraints. These requirements have been repeated to relevant staff and managers by the Governor, who is confident that decisions taken now are much better informed and consider each prisoner's health and mobility.</p>	<p>Head of Security 31 August 2014</p>
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