Investigation into the circumstances surrounding the death of a man in June 2011 at HMP Kingston

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Kingston, Portsmouth, Hampshire in June 2011. He was 70 years of age. The cause of death was carcinomatosis, this being a condition resulting from widespread dissemination of carcinoma (cancer) in multiple sites in various organs or tissues of the body;

The man was remanded into custody on 21 November 1969 and sent to HMP Wakefield. He was later sentenced to life imprisonment with a 12 year tariff, due to expire in 1981. After he was sentenced, he spent time at various other establishments including HMP Preston and HMP Albany, and arrived at Kingston on 1 November 2004

The man had no next of kin. I would like to offer my sincere sympathy and condolences to all who may have been affected by his death.

The investigation was carried out by one of my colleagues. She and I would like to thank the Governor of HMP Kingston and his staff for their assistance.

Hampshire Primary Care Trust (PCT) commissioned a clinical reviewer to review the man's clinical care. I appreciate his help and contribution to the investigation.

I make three recommendations as a result of this investigation. These include delays in sending referral letters to hospital, assisting prisoners in planning matters in respect of their approaching death, such as drafting a last will and testament, and the use of restraints in 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2011**

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SUMMARY

1. The man arrived at HMP Kingston on 1 November 2004. During his time there, he worked in the prison gardens and it was noted in his medical records that he had a good diet and was in good health. In February 2009, he underwent a coronary bypass operation. However, it was noted only three months later that he had made an excellent recovery from the surgery.

2. On 28 March 2011, the man went to healthcare complaining of dark urine. His urine was tested, and after a positive test for proteins, a sample was sent off for further examination. The next day, his urine result was received. The sample contained no abnormalities, and no further action was taken.

3. However, the man continued to suffer from dark urine and, on 14 April, he visited health care seeking advice. After further examination it was noted by the nurse that he was now suffering from yellowing of the eyes, and increased bowel movements. As he had multiple symptoms, the man was seen for an urgent review by the prison doctor the next day.

4. A doctor examined the man and noted that he was suffering from jaundice and conjunctivitis, and had pain in his upper abdomen. It was explained to him that a referral would be made to the gastroenterology department at outside hospital.

5. The man was seen by a gastroenterologist on 10 May. During this consultation, he was told that he might have cancer, and a CT scan (a three dimensional x-ray) was booked for 17 May.

6. On 15 May, the man collapsed on the wing vomiting blood. He was taken to the Medical Assessment Unit at outside hospital where he was advised that he would be staying overnight for further tests. The following day he had a procedure where a camera was placed down his throat (known as an ERCP) to allow the doctors to examine his gallbladder, bile duct, and pancreatic duct without the need for an operation.

7. The man met with another hospital consultant on 17 May. He was told that he had carcinoma (cancer) at the head of his pancreas with liver metastases (cancerous tumors that have spread to the liver from elsewhere in the body). He was told that his cancer was terminal and untreatable.

8. The man remained in hospital, and the services of the palliative care team were sought. The Head of Healthcare at Kingston sought alternative accommodation for him at either HMP Winchester (who have 24 hour healthcare), or at a hospice. However, due to a rapid decline in his health he died at 2:23am on a day in early June.

9. I make three recommendations as a result of this investigation. These concern delays in sending referral letters to hospital, assisting prisoners in planning matters in respect of their approaching death, such as drafting a last will and testament, and the use of restraints in hospital.

THE INVESTIGATION PROCESS

10. The investigation was opened on 2 June 2011, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward asking to speak to her.

11. During the opening visit on 8 June, the investigator collected copies of the man's prison files, including his medical records. She met with the Modern Matron and also Head of Healthcare to discuss the care the man received whilst at Kingston. My investigator also viewed the man's cell and introduced herself to the staff on the wing.

12. On 27 June, a call was received by an Assistant Ombudsman from a person who wished to remain anonymous. This person said that she was a wife of a prisoner at Kingston. She made numerous allegations about the standard of the care prisoners were receiving. The information received was passed to the investigator as the man who is the subject of this report was mentioned in the allegation.

13. The investigator returned to Kingston on 2 August, to interview two members of staff, the Head of Healthcare and a nurse. On the same day, with the assistance of her colleague, an investigator dealing with another death at Kingston, she discussed the allegations with the Head of Healthcare. The details of this allegation can be found in the main section of this report.

14. Throughout the investigation, the investigator gave feedback to her prison liaison officer who was also the Reducing Re-offending Manager. On completion of her investigation, the investigator and her colleague met with the Governor highlighting areas of concern.

15. To gather further information for the purposes of the investigation on 5 July, the investigator contacted a member of staff from the palliative care team at outside hospital. The member of staff from the palliative care team was able to provide the investigator with copies of the clinical notes she made during her visits with the man. She advised that a full copy of the man's palliative care documents (including his end of life care pathway) would be contained in his hospital records. My investigator subsequently requested the man's hospital records, which were received on 1 August.

16. A clinical review of the man's health care in prison was carried out by a clinical reviewer on behalf of the Hampshire Primary Care Trust.

17. A family liaison officer was appointed for the investigation. However, no next of kin was identified.

18. A post mortem was carried out on 6 June 2011. This report will be forwarded to the coroner to assist in their enquiries.

19. My investigation assesses the following aspects of the man's care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether the man was told about his condition and the treatment which followed?
- Whether he was treated properly and attended hospital appointments as necessary?
- Whether the liaison with the man's family was appropriate?
- Whether the man was accommodated in the most appropriate part of the prison?
- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

HMP KINGSTON

20. HMP Kingston is a men's prison, located in Portsmouth, Hampshire, which caters for both Category B (prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult) and C (prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape) life sentenced prisoners. Accommodation in the main prison is made up of single occupancy cells for Category B prisoners. In addition, there is a smaller unit holding Category C prisoners. Accommodation on this unit comprises of multi-occupancy rooms.

21. Health services at HMP Kingston are commissioned and provided by the Hampshire City Primary Care Trust (PCT). Staffing in healthcare consists of two primary care nurses, a mental health nurse, an administrator and two nurses to deliver the Integrated Drug Treatment System (IDTS) to prisoners with drug and alcohol problems. Visiting doctors hold surgeries on Mondays, Wednesdays and Fridays. Healthcare is open from 8.00am until 6.00pm on weekdays and from 8.30am until 1.00pm on weekends. At all other times, there are no healthcare staff on site, and prison officers need to contact an out of hours service for advice if a prisoner becomes unwell.

22. The man lived in The Elderly Prisoners' Unit. This unit was established in 1997 for life sentence prisoners over the age of 60, who may have health problems, but are mobile and do not require full-time nursing care. This unit is staffed by a mixture of discipline and health care staff.

The Independent Monitoring Board (IMB)

23. The IMB in their most recent report, dated 2010 said that:

> "The prison benefits from an excellent Health Care service. Although provided through the local NHS Trust, the service is extremely well integrated into the management of the prison and the inclusion of the Modern Matron as a member of the Senior Management team ensures very effective joint working. The Board continues to be reassured to know that prisoners in Kingston receive the same quality of primary health care services as they would from a GP practice in the community".

HM Chief Inspector of Prisons (HMCIP)

24. The last inspection of Kingston was conducted by the then Chief Inspector in 2010. In her foreword, she commented:

> "The inspection reaffirmed previous findings that Kingston is a safe and decent place, and also applauded the purposeful regime and sound focus on addressing the risks posed by the very serious offenders in the prison's care. Each primary care nurse was the clinical lead for a long-term condition, including asthma, cardiac problems and diabetes. The vision [computer] system contained chronic disease registers, and patients with lifelong conditions had appropriate careplans with set review dates.

Nurses visited prisoners on the wings if necessary and, with their consent; summaries of careplans for prisoners with complex health needs were placed in the hub office to give uniformed officers information on how best to support them during acute situations".

Previous deaths in custody

25. Since 2009 there have been three deaths at Kingston, all being from natural causes. This man died of cancer, and bears no similarities to the two other deaths.

ISSUES

The diagnosis of the man's terminal illness

26. The man arrived into HMP Kingston on 1 November 2004. On 15 January 2010, during a health review it was noted that the man liked the gym, playing football, and despite having heart surgery in 2009, there were no indications for concern. The nurse who examined him that day also commented on his overall health, saying that he was a non-smoker and had a good diet and lifestyle.

27. On 28 March 2011, the man went to healthcare complaining of dark urine. He was seen by a nurse who spoke to him asking if he had any other symptoms. He said that there was no discomfort or increase in frequency or urgency when urinating. The nurse tested his urine, which revealed a positive result for protein. Due to this, a sample of his urine was sent off for further examination.

28. The next day, the man's urine result was received. The report on the sample showed no abnormalities, and it was decided that no further action was required.

29. However, the man continued to suffer from dark urine and, on 14 April, visited health care seeking advice. It was noted by a nurse that he was now suffering from yellowing of the eyes, and after further questioning the man revealed that his bowel habits had changed considerably. He stated that his bowels opened around ten times each day, and that his faeces were now a very pale beige colour. It was decided that in view of the multiple symptoms, he should see the prison doctor the next day for an urgent review.

30. The prison doctor saw the man the next day, 15 April. The man explained that he felt unwell, and had for the past three to five weeks been passing dark urine and pale stools. It was noted by the doctor after examination that the man was now suffering from jaundice, conjunctivitis, and had pain in his upper abdomen.

31. However, the doctor was unable to give an exact diagnosis, believing he could be suffering from either, pancreatic steatorrhoea (lack of intestinal juices resulting in fatty faeces), painless obstructive jaundice (a condition caused by a blockage restricting the flow of bile out of the liver which then results in an overflow of bile and by-products into the blood, resulting in bilirubin, a pigment derived from dead red blood cells, giving a yellow appearance to the skin and eyes), or liver/ gallbladder disease. A sample of his blood was sent for further examination, and it was explained that a referral to the gastroenterology department at outside hospital would be made.

32. The clinical reviewer commented that, although the man's urine was tested for protein on 28 March, it is unclear whether the testing sticks used also tested for bilirubin (which would have been indicative of jaundice). If they had been

used, this may have reduced the time between presentation to the healthcare nurse and the decision to refer to a doctor on 14 April.

33. Although the decision to refer the man to the gastroenterology department was made on 15 April, the referral letter was not sent until 27 April. The referral letter detailed the man's symptoms, his current medication, and commented that "my impression is painless obstructive jaundice e.g. tumour, pancreatic causes: e.g. tumour? Liver causes".

34. On 10 May, the man was seen by a consultant gastroenterologist. My investigator emailed the prison doctor asking why there was a delay in sending this referral letter. The prison doctor explained that:

> "I consulted with [the man] on the 15th of April. I dictated a letter to a dictaphone on the day, and handed the tape to the nurse working with me. On Monday 18th of April I was requested by the Healthcare Matron to write a letter myself as the secretary was on annual leave, and the dictation could not be done from the tape done on the 15th of April. I typed a referral letter as requested, saved the letter on the patient's records, printed a copy of this letter, and handed it to the nurse working with me on the day. Beyond this I had no further involvement".

35. After reading this email, the clinical reviewer highlighted that "there is a nationally agreed NHS policy for the referral of patients who are considered to have a possible diagnosis of cancer. That policy requires the referral to be made by fax within 48 hours of the referring clinician seeing the patient". This letter was not faxed within the agreed 48 hour target.

36. On 10 May, the man was seen by a consultant gastroenterologist at outside hospital. The consultant gastroenterologist examined the man and explained that the likely diagnoses were either gallstones or a tumour of some kind. The consultant gastroenterologist advised him to discontinue clopidogrel (a medication used to prevent blood clotting) as he was likely to need some form of surgical intervention. A CT scan (Computerised Tomography scan: CT scans are far more detailed than ordinary X-rays. A normal x-ray would only show a 'flat' two dimensional picture, whereas a CT scan produces three-dimensional images. They can be used to produce virtual images that show what a surgeon would see during an operation, allowing doctors to inspect the inside of the body without having to operate) was booked for the man on 17 May. A clinic letter was sent to healthcare at Kingston on 13 May, detailing the consultation with the man that day.

37. Five days after being examined by the consultant gastroenterologist, at 10:50am on 15 May, the man collapsed vomiting. (The type of vomit he produced is known as "coffee ground vomit". Blood contains iron within red blood cells. When this iron has been exposed to gastric acid for some time, it becomes oxidized. This reaction causes the vomit to look like ground coffee. Coffee-ground vomit is a classic sign of upper gastro-intestinal bleeding.) Paramedics were called and the man was taken to healthcare, where he told staff that he was experiencing intense pain in his abdomen area.

38. When paramedics arrived observations were taken. It was decided that, because the man was now in a stable condition, he should be admitted to the Medical Assessment Unit (MAU) at outside hospital rather than by ambulance to the Accident and Emergency department. It was felt that by going to the MAU, the man would receive a better level of care, with staff being able to provide rapid diagnostic assessment. He could then be directed to the clinical area most appropriate for his condition.

39. The Head of Healthcare contacted MAU and made a referral. The man was taken by taxi to hospital, leaving the prison at 11.30am. He arrived at outside hospital at 11:45am, and was taken to the MAU where he was seen by a doctor. On arrival, samples of his blood were taken and it was explained that he would need to stay in overnight.

40. On 16 May, the man had an Endoscopic Retrograde Cholangio-Pancreatography (ERCP). (An ERCP is a procedure where a flexible tube is put in through the mouth, down the oesophagus (food pipe), past the stomach into the small bowel (intestine). This procedure allows surgeons to examine the gallbladder, bile duct, and pancreatic duct without operating).

41. The next day, the man was seen by a consultant to discuss the results from the ERCP procedure. The consultant explained that the ERCP showed that he had carcinoma (cancer) at the head of his pancreas with liver metastases (cancerous tumours that have spread to the liver from elsewhere in the body). It was explained to him that his cancer was terminal and untreatable.

42. The man's cancer was diagnosed on 17 May, seven days after he was seen by the consultant gastroenterologist at outside hospital. He was seen there within two weeks of receipt of the referral letter from the prison doctor. However, there was a delay of 12 days in sending this referral letter to outside hospital. The clinical reviewer commented that, "in view of the eventual diagnosis, this delay would have made no difference to the outcome either in respect of cure or timescale to [the man's] death".

43. The Head of Healthcare reviewed the man's medical records, and completed a root cause analysis after he died. She highlighted at interview that she was aware of the delay in sending the referral letter to the gastroenterology department at outside hospital. She provided the investigator with a copy of her root cause analysis (a problem solving method aimed at identifying the root causes of problems or events), showing a plan of action to ensure that a delay of this nature would not happen again. The Head of Healthcare made a recommendation that "should there be no administrator, issues of referrals not being processed in a timely manner could result in unnecessary delay. A clear process for backfill in this post needs to be agreed". The Head of Healthcare set November 2011 as the target date for this to be actioned.

44. I am pleased that the Head of Healthcare has looked at a way of improving the process of referring patients to hospital. Despite this, to further reinforce

the importance of timeliness in sending hospital referrals, the clinical reviewer makes the following recommendation, which I endorse:

> **Healthcare and prison staff should be made aware that events such as 'two week rule' referrals are urgent and cannot be delayed for administrative reasons. A protocol should be developed with clear lines of responsibility to ensure that delays do not occur.**

Informing the man about his condition and treatment

45. The man attended healthcare on 14 April, complaining that he had been passing dark urine since 28 March and was having to open his bowels on average ten times each day. In view of his multiple symptoms, he was seen by a prison doctor the next day for an urgent review.

46. On 15 April, the prison doctor explained a possible diagnosis. The doctor told him that she believed that he may have pancreatic steatorrhoea (lack of intestine juices leading to fatty faeces), painless obstructive jaundice or a form of liver or gallbladder disease. She informed the man that he was to be referred for further examination at the gastroenterology department at outside hospital.

47. Following this appointment, the man was reviewed by healthcare staff on 18 April. It was noted in his medical records that "[the man] to be kept informed of all actions and outcomes. He may wish for situations NOT to be shared with others."

48. The man met with a consultant gastroenterologist on 10 May, where the possibility of a cancer diagnosis was discussed. The consultant explained that he may simply have gallstones causing a blockage, or that it could be a cancerous tumour.

49. On 17 May, the man met with a doctor from outside hospital where he received a full diagnosis. During this meeting, pain relief was explained, including the possibility of palliative chemotherapy (the use of chemical substances to slow the progression of cancer and prolong life).

50. Whilst the man was in hospital, he had regular visits from the Head of Healthcare. After his diagnosis, visits were arranged with a palliative care nurse from outside hospital, to make sure he was fully aware of his condition, prognosis and treatment.

51. The man met with the prison doctor on 4 May, before he was admitted to hospital. During this meeting he explained to her that "he wants to know everything that is going on with his health even if it is bad news." The clinical reviewer is of the opinion that the man's request was adhered to. I agree with this view.

The man's medical appointments and treatment

52. After a referral to the gastroenterology unit at outside hospital, the man was seen by a consultant gastroenterologist on 10 May. He was then later admitted to outside hospital on 15 May after he collapsed at Kingston. He was admitted to hospital before a substantive diagnosis had been made, and remained there until his death. During his time in hospital, the Head of Healthcare visited him regularly and liaised with hospital staff. Prior to his diagnosis and admission into hospital, the Head of Healthcare informed prison staff that hospital appointments were not to be cancelled or rearranged because of staffing or other operational difficulties.

53. It is the opinion of the clinical reviewer that the appointments and the treatment received by the man were to an appropriate standard. I support this view.

The man's pain relief and medication

54. The man visited healthcare on 27 April complaining of insomnia. He explained to the prison doctor that he was unable to sleep due to abdominal pain. He said that because of the severity of the pain, the only way he could receive some comfort was to sleep in a reclined position. The prison doctor prescribed amitriptyline 10mg (an antidepressant that can be used in small doses as a pain reliever by blocking certain receptors in the brain). However, the man reported that this made no difference to his insomnia.

55. Over a period of eight days, the dosage of amitriptyline was increased. By 4 May, the dosage of amitriptyline had been increased from 10mg to 75mg, with an additional prescription of promethazine 50mg (an anti-histamine) added for night time use, to try and ease the itching caused by his jaundice.

56. Despite the continued efforts of healthcare staff, on 8 May, the man was still unable to settle at night due to continued abdominal pain and itching. It was decided by the prison doctor and the Head of Healthcare that because they had tried so many options with pain relief, they would now try tramadol (an opiate based pain relief) hoping this would alleviate some of his abdominal pain.

57. During a review with healthcare staff on 14 May, the man said that the introduction of tramadol had helped with his pain control at night, and he had slept for 13 hours the previous night. However, he commented that although he was now able to sleep at night, as the day progressed the pain in his left side would become more pronounced.

58. After the man's hospital admission on 15 May, his pain levels increased significantly. A comment was made in the prison bedwatch log on 26 May to say "[The man] has his eyes closed and is making noises as if he is in pain". As he continued to be in pain, he was prescribed morphine (a potent opiate based pain reliever) by hospital staff.

59. On 27 May, the man was still in severe pain. After discussion with the palliative care nurse, diamorphine (an extremely potent opiate based pain reliever) was administered. The same day, to ensure he was as comfortable as possible a syringe driver (a small infusion pump used to gradually administer small amounts of medication into the bloodstream) was fitted for use with Alfentanil (a potent but short-acting synthetic opioid analgesic drug) and midazolam (a short-acting drug that is used for treatment of acute seizures, moderate to severe insomnia, and for inducing sedation and amnesia before medical procedures).

60. Throughout his illness, both before and after his diagnosis, the man suffered from severe discomfort and pain. The clinical reviewer commented that:

> "before his admission to hospital and a definitive diagnosis [the man] was continually troubled with insomnia and intractable itching. The itching associated with jaundice is notoriously difficult to control, but appropriate medication was prescribed and modified in an attempt to bring his symptoms under control, and changes in medication ordered by [outside] hospital were made in a timely manner".

61. The clinical reviewer was of the view that appropriate pain relief and medication was given to the man. I further support this view.

Liaison with the man's family

62. The man had no known next of kin. Despite this, on 27 May, the Head of Healthcare asked the Deputy Governor to make enquires. No next of kin could be traced.

The man's location

63. The man received his diagnosis on 17 May. During a visit from the Head of Healthcare the same day, he expressed his wish to return to Kingston. The Head of Healthcare said that she would do her best to enable this to happen, explaining that due to his condition this might not be possible.

64. On 24 May, it was noted in his hospital records that he was "not for resus" and should not be resusitated if the need arose. Due to a deterioration in his health it was decided that a return to Kingston would not be appropriate. The Head of Healthcare contacted HMP Winchester to ask about the possibilty of transfering him to their inpatient unit where he could receive 24hr care. Winchester said that as long as he was fit for transfer they would accept him.

65. Between 24 and 27 May, the man's condition deteriorated considerably. He was now unable to get out of bed, had a catheter inserted, and was suffering from bouts of confusion. The Head of Healthcare spoke with the palliative care nurse on 27 May to discuss the man's care. It was decided that it would be better for him if he were moved to a hospice rather than Winchester.

66. On 30 May, it was agreed that as the man has deteriorated, he was not well enough to be moved out of the hospital. It was decided that he should remain at outside hospital for his final hours of life.

67. The man expressed his wish to remain at Kingston, and not be transferred to Winchester. The Head of Healthcare planned to keep him at Kingston in accordance with his wishes, but this was not possible due to a sudden deterioration.

Compassionate release

68. The man was sentenced to life imprisonment in 1969, with a 12 year tariff, expiring in 1981. In late July 2010, after continued efforts by his offender supervisor, the man received an IEP (Incentives and earned privileges) warning downgrading him from 'enhanced' to 'standard' for his lack of participation and co-operation with the sentence planning review process.

69. Further to this IEP warning, in August the man submitted a 'comp 1' form making a complaint about his offender supervisor who was based at the prison. In this complaint, he said:

> "my attitude towards release (including engagement with probation and psychology staff, and any sentence planning measures) remains unchanged, that is to say I no longer look to be freed on license and, in the unlikely event of the Parole Board directing my release, I would absolutely decline it. If I am obliged to attend any meeting or interview directed at 'progressing' me towards release, it will be under duress".

70. The offender supervisor commented in a sentence planning and review report on 15 September that "I offered [the man] the opportunity for interview on 7 September for the purpose of a parole report but he declined this offer". Not only did he decline to meet with his offender supervisor, he signed a 'waiver' form instructing his offender supervisor that he did not wish to meet with him for the next six months. The next appointment was scheduled for March 2011.

71. On 29 September 2010, a parole dossier was sent to the man, asking him to make representations to the parole board. He returned the document the next day confirming that he had no wish to be represented, nor did he wish to be considered for release. On 14 January 2011, he received his parole board review notice confirming that his application for parole had been unsuccessful. He was asked to read and sign the document to confirm that he was aware of the decision. The man, not wanting to be released, refused to read or sign the document, and ripped it up.

72. On 18 March, the man signed a further six month waiver form, confirming that he did not wish to engage with the probation service. The sentence planning and review report submitted by his offender supervisor in September 2010 stated:

> "Currently 29 yrs over his tariff he has not addressed any of his offending behaviour, and is adamant that he wants to remain in prison, and subsequently is not willing to engage with either his seconded probation officer, or his external probation officer. Further to this he has not addressed the risk he poses to the public, which has not been addressed since he was incarcerated in 1969 other than completing the 'enhanced thinking skills' in 1994."

73. On 24 May, due to a deterioration in health, it was decided that a return to Kingston would not be appropriate. The Head of Healthcare contacted HMP Winchester to ask about the possibilty of transfering him to their inpatient unit, where he could receive 24hr care. However, when he was reviewed on 27 May, it was decided that due to further deterioration it would be better if he were moved to a hospice rather than Winchester.

74. The Head of Healthcare spoke to a hospice on Friday 27 May to ask if they would agree to accept the man. The hospice agreed to accept him. However, they explained that the earliest they could accept him would be Monday 30th May.

75. On 30 May, it was agreed that as the man had deteriorated further, he was not well enough to be moved out of the hospital. It was decided that he should remain at outside hospital for his final hours of life.

76. Due to the man's continued assertions that he did not wish to be considered for release, and because of the six month waiver form he signed three months before his death, compassionate release was not considered. I agree that this decision was appropriate.

Palliative care plans

77. Following on from the man's diagnosis on 17 May 2011, palliative chemotherapy was considered. However, due to his rapid deterioration in health and the advancement of his cancer, it was felt that he would receive no benefit.

78. On 26 and 27 May a palliative care nurse met with the man. During these meetings the palliative care nurse discussed aspects of his care including pain relief.

79. Due to deterioration in health on 27 May, the man was put on the Liverpool Care Pathway (LCP). (The LCP is an integrated care pathway that is used at the bedside to ensure quality of care for the dying in the last hours and days of life. This is designed to ensure that the patient has sufficient pain relief and that their religious/spiritual wishes are taken into consideration.)

80. The clinical reviewer commented that once the pathway had been initiated it was correctly followed and the man's terminal care was appropriate and of a high standard. He further commented that, by the time the careplan was initiated, the man had only limited ability to participate in agreeing treatment

plans, but he had previously voiced his wishes in a general way. The treatment which followed was, as far as possible, in accordance with those wishes.

81. Further to the end of life care received by the man, it was noted in a bedwatch log that on 17 May he asked if he could make a will. The bedwatch log detailed "[The man] wants to make a last will and testiment. Been given pen and paper to write his last will. [The man] very calm and relaxed, writing his will". The man did not have family, but it is believed that he wanted to leave some of his belongings to a friend on the wing. Enquires were made with the Head of Healthcare and my investigator's prison liaison. My investigator was initially told that they were unaware of the existence of any such will. However, on 31 August, she received an email from the prison liaison to say that the will had been found. The man requested that his clothing, CDs and £400 he received from premium bonds be given to named individuals at Kingston. The prison liaison and Head of Healthcare were unaware of the existence of this will, and because of this, the man's wishes had not been actioned. My investigator was told that, due to the man having no family, after his death, his personal possessions had been collected and still remained on the premises.

82. The clinical reviewer commented that the palliative end of life care was of an appropriate and high standard. However, with regard to the man's will, I make the following recommendation:

> **Terminally ill prisoners should be given assistance in planning matters in respect of their approaching death, for example making a last will and testament. If the person chooses to make a will, this should be clearly identified in their prison records, and acted on after the person has died.**

Restraints, security and bed watch

83. The man was admitted to outside hospital on 15 May 2011, after he collapsed on the wing. Due to his offences, he remained handcuffed to an officer at all times. On 16 May, an officer requested that the handcuffs be removed to allow the man to have a CT scan (three dimensional x-ray), and this was agreed. Once the procedure was completed the handcuffs were reapplied.

84. On 23 May at 9.00am a prison officer wrote in the man's bedwatch log "prisoner is extremely confused talking jibberish, seems to be seeing things". Further to this, it was noted on the same day that he was unable to eat very much and had to on three occasions be cleaned and changed by nursing staff due to him being unable to control his bowels. Due to deterioration in his health, he was no longer able to get out of bed, now having to use a wheelchair.

85. A security review was completed by the Duty Governor on 25 May. The Duty Governor confirmed that as the man had been unable to leave his bed since 23 May; his level of risk had reduced. Instructions were given that restraints

could be removed whilst he was in the hospital room. However, it was explained that in the absence of handcuffs, staff must be positioned, one on either side of the bed, only reapplying the handcuffs if he had to be moved out of his bed.

86. After reviewing the relevant medical files, the clinical reviewer commented that "although it is now difficult to be certain, I feel from the clinical record that this decision could have been made a day or two earlier". I agree. The man was a very ill, elderly man, and two prison officers should have been able to ensure public safety around him.

87. It seems that by 23 May the man's condition had deteriorated to the point where restraints were no longer necessary. However, restraints were not removed until 25 May. I believe this delay was unnecessary. While I accept that prisons have to make risk assessments and to take public safety into account. However, I feel on this occasion the use of restraints should have been reviewed more regularly, and that the restraints should have been removed at an earlier stage. I therefore make the following recommendation:

The Governor should ensure that when restraints are used, their continued use is reviewed on a regular basis and the risk assessment reflects changes in the prisoner's condition.

The anonymous allegation made on 27 June

88. On 27 June, the Prisons and Probation Ombudsman's office received a call from a person who wished to remain anonymous. This person said that she was a wife of a prisoner currently held at Kingston. She made numerous allegations about the standard of the care prisoners were receiving. My investigator and her colleague (who investigated the recent death of another prisoner at Kingston) spoke to the Head of Healthcare at length. The Head of Healthcare was able to address each allegation, pointing out factual inaccuracies in what the caller had said.

89. Due to issues of confidentiality this report will only detail the issues directly linked to this man and the care he received.

90. There is no record of the man making any complaints to the Prisons and Probation Ombudsman. My colleague examined the log of internal complaints made by prisoners about healthcare. The Head of Healthcare demonstrated that the complaints are all personally answered, audited on a monthly basis and sent to the local Primary Care Trust for further analysis, to ensure that there is no identifiable pattern of complaints about a particular member of staff or service.

91. In regards to the man, it was alleged that he was very unwell with liver damage. It was commented that, due to him being unwell, his eyes turned a shade of yellow. However, when he went to healthcare about this, he was ignored. He allegedly kept going back to healthcare complaining about this,

and because this was never treated he had to resort to wearing dark glasses to hide his eyes.

92. The man's eyes did turn a shade of yellow. When this was noticed by a nurse on 14 April, he was referred to a prison doctor for an urgent review and saw her the next day. Following this review, he was referred to the gastroenterology department at outside hospital. The Head of Healthcare was asked to comment on the allegation relating to the dark glasses. She explained that the man did wear glasses, but that these had 'photochromic' lenses (transition lenses) in them. She explained that these kind of lenses, when placed in direct sunlight, would darken effectively turning them into sunglasses. These enabled him to work in the gardens with ease.

93. The clinical reviewer was present at the interview when the allegation was discussed with the Head of Healthcare. He noted in his clinical review that he was satisfied with the level of care that the man received at Kingston.

CONCLUSION

94. The man was sentenced to life imprisonment in 1969, with a 12 year tariff which expired in 1981. Whilst at HMP Kingston he worked in the prison gardens and was generally good heath.

95. On 28 March 2011, the man went to healthcare complaining of dark urine. After further investigation, it was decided that no further action was required. He was then seen 17 days later, on 14 April, when he complained of continued symptoms.

96. After being seen by the prison doctor the following day, it was decided that a referral should be made to the gastroenterology department at the local hospital and a letter was sent. However, there was a 12 day delay in sending this letter. The clinical reviewer commented that "in view of the eventual diagnosis, this delay would have made no difference to the outcome either in respect of cure or timescale to [the man's] death".

97. After a diagnosis was received on 17 May, and an unplanned emergency admittance to outside hospital, the services of the palliative care team were sought. The clinical reviewer felt that his end of life care was appropriate and of a high standard.

98. The man was not considered for compassionate release. In August 2010, he expressed his wish to remain in prison, writing in correspondence: "I no longer look to be freed on license and, in the unlikely event of the Parole Board directing my release, I would absolutely decline it".

99. Further to this, the man signed two waiver forms (valid for six months) confirming that he wanted no contact with the probation service, the most recent form being signed three months before his death. Towards the end of his life he had limited ability to participate in agreeing treatment plans, but he had previously voiced his wishes in a general way and what occurred was, in as far as possible, in accordance with those wishes.

RECOMMENDATIONS

1. Healthcare and prison staff should be made aware that events such as 'two week rule' referrals are urgent and cannot be delayed for administrative reasons. A protocol should be developed with clear lines of responsibility to ensure that delays do not occur.

   Accepted – An algorithm has been produced to ensure that future absences of administrative staff will not impact upon the performance of these associated tasks. The responsibility for action in the absence of the administrator has been set with the most senior healthcare professional on duty on the day the referral is made. **Completed**.

2. Terminally ill prisoners should be given assistance in planning matters in respect of their approaching death, for example making a last will and testament. If the person chooses to make a will, this should be clearly identified in their prison records, and acted on after the person has died.

   Accepted – Joint PCT Prison protocol to be produced to fully reflect and manage those specific issues associated with approaching death. **Target date 31 December 2011.**

3. The Governor should ensure that when restraints are used, their continued use is reviewed on a regular basis and the risk assessment reflects changes in the prisoner's condition.

   Accepted – Full assessment will be undertaken at each stage of condition change. **Completed**.