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 at HMP Preston on 2 July 2013

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'

This is the investigation report into the death of a man, who died of bronchopneumonia on 2 July 2013 at HMP Preston. He was 77 years old. I offer my condolences to the man's family and friends.

The man was sentenced to 12 years imprisonment in November 2010 and sent to HMP Manchester. He suffered with a number of longstanding chronic medical conditions and his mobility was limited. He transferred to HMP Wymott in November 2012 and, in January 2013, had a leg amputated after developing vascular problems. After the operation, he moved to HMP Preston for a period of rehabilitation in the prison's impatient unit.

While he was at Preston, the man's health deteriorated further. He was admitted to hospital five times and restraints were used on each occasion. However, at hospital his risk was reassessed and temporary release authorised each time, meaning that the restraints were then removed and he was escorted by a single officer. In June 2013, he was diagnosed with bronchopneumonia, but refused any treatment. In the last days of his life, there was some confusion about whether to initiate a care pathway for the dying, but the man died peacefully and without pain.

I am not satisfied that the use of restraints when the man was taken to hospital from Preston was justified by fully considered risk assessments, indeed the approach taken was inconsistent and confused. The investigation also identified a need for staff training in end of life care at Preston. However, the clinical reviewer was satisfied that, overall, the man received appropriate care and treatment in prison which was equivalent to that which he could have expected in the community. I agree that his general care was good.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was convicted of serious offences on 5 October 2010. On 19 November, he was sentenced to 12 years imprisonment and went to HMP Manchester. Before his imprisonment the man had been diagnosed with a number of chronic conditions. He had undergone a left hip and knee replacement which impacted on his mobility. At Manchester, he lived in the prison's inpatient unit.

2. While he was at Manchester, the man was diagnosed with chronic obstructive pulmonary disease (COPD – a lung condition) and diabetes. He was transferred to HMP Wymott on 5 November 2012, but his health deteriorated further and he developed vascular problems. In January 2013, he had a leg amputated below the knee.

3. When he was discharged from hospital on12 February 2013, the man was moved to HMP Preston's inpatient healthcare unit for rehabilitation. His health continued to deteriorate and he began to refuse food and treatment. He was admitted to hospital a number of times for problems associated with his various chronic conditions.

4. On 22 June, the man was admitted to hospital again with complications related to his COPD. He was diagnosed with bronchopneumonia (acute inflammation of lungs) for which he refused treatment. The hospital therefore discharged him back to HMP Preston the same day.

5. On 1 July, the man's health deteriorated further and a nurse requested that an end of life pathway should be considered. A doctor agreed that the man was nearing the end of his life but wanted to take advice from a specialist in palliative care before beginning the pathway.

6. The doctor reviewed the man the next morning and did not consider an end of life care pathway needed to be initiated at that time. The man's condition deteriorated further during the day. At 3.49pm, nurses began an end of life pathway. They were unable to contact a doctor to prescribe additional palliative medication but the man remained comfortable and pain free. He died at 4.50pm with nurses present.

7. The man was taken to hospital five times while at Preston. On each occasion he was restrained with an escort chain. Each time, he was then released on temporary licence the next day, restraints were removed and he was accompanied by one officer.

8. The clinical reviewer is satisfied that the mans clinical treatment was equivalent to that he might have expected to receive in the community. His health conditions were well managed despite his refusal of medication and food. We make two recommendations about palliative care training and about the use of restraints.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Wymott and HMP Preston informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

10. The investigator interviewed four members of healthcare staff at Preston on 22 August and four healthcare staff at Wymott on 30 August. The investigator obtained copies of the man's prison records and prison medical records.

11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

12. HM Coroner for Preston and West Lancashire district was informed of the investigation and provided the investigator with the results of the post-mortem examination. The Coroner has been sent this report.

13. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin to explain the investigation. The man's son did not have any specific matters for the investigation to consider. The man's family received a copy of the draft report and was given the opportunity to comment on the contents. After reading the draft report the family had no comments to make.

14. The investigation has assessed the main issues involved in the man's care. This included his diagnosis, treatment, appropriate palliative care, family liaison, his location, compassionate release and security arrangements for escort and bedwatch.

HMP PRESTON

15. HMP Preston is a local prison holding up to 842 adult male prisoners. Health services are provided by Lancashire Care Foundation Trust. The healthcare unit has an inpatient unit for up to 30 prisoners with mental and physical health problems which is used as a regional facility. Admission from other prisons is by referral and patients remain the responsibility of their original prison for all issues except healthcare.

16. There is a full-time doctor covering the inpatient unit and primary healthcare 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. At night and weekends there is on-call cover.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons last inspected 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 prisoners living there.

Independent Monitoring Board

18. 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 that prisoners are treated fairly and decently. In their latest published annual report the IMB commented that a number of patients had been looked after in the healthcare facility at the end of their lives and some had received commendable care.

Previous deaths at HMP Preston

19. There have been ten deaths at Preston since 2011, six from natural causes. Issues identified during previous investigations relating to the use of restraints and risk assessments are repeated in this report.

ISSUES

20. The clinical reviewer considers that the man's care in prison was equivalent to that he could have expected to receive in the community. However she makes a number of recommendations to the healthcare leads at both Wymott and Preston which they will need to consider.

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

21. The man had a number of chronic conditions including rheumatoid arthritis and osteoarthritis (conditions that cause pain and inflammation in the joints), brittle bone disease, atrial fibrillation (an irregular heartbeat), type 2 diabetes, peripheral vascular disease (narrowing of the arteries, usually in the legs) and congestive obstructive pulmonary disorder (COPD – a lung condition that causes difficulty breathing due to long term damage to the lungs). The man had also had a left hip and knee replacement before coming into prison. He was very weak, had limited mobility and received assistance with personal care.

22. In January 2013, due to vascular disease, the man's left leg was amputated below the knee. When he was discharged from hospital on 12 February 2013, he moved to HMP Preston for a period of rehabilitation in the prison's inpatient unit. However, his health continued to deteriorate. In May, he contracted a bacterial infection which resulted in another stay in hospital, during which time he became very weak. He began to refuse food and medication.

29. On 22 June, the man was admitted to hospital with respiratory problems related to COPD. While in hospital, he was diagnosed with bronchopneumonia. The seriousness of his condition was explained to him by hospital staff but he refused any treatment. Prison healthcare staff were informed that he had refused treatment for his condition and he was discharged to Preston the next day. The man died at 4.40pm on 2 July.

30. Records show that the man was very well looked after by prison healthcare staff. His range of conditions and their treatment were frequently discussed with him. His terminal illness was diagnosed in hospital and we are satisfied that the man was aware of the seriousness of his condition and had the mental capacity to refuse treatment.

The man' medical treatment

31. It is unclear from the records exactly when the man was diagnosed with COPD, although it appears to have been in 2011. He was prescribed prednisalone (a steroid medication used to treat inflammatory conditions such as asthma) to assist his breathing.

32. Records show that the man's medical conditions were regularly reviewed and treated and he had appropriate care plans. Throughout his time in prison the man was very weak and his appetite was much reduced.

33. After his lower leg was amputated, the man's appetite continued to decline and his physical health deteriorated. Despite repeated encouragement from healthcare staff, the man continued to eat and drink very little. He became malnourished and underweight and began to refuse all treatment. The man's mental health was reviewed and it is evident that he had the mental capacity to make decisions about his nourishment and treatment.

38. The man's weak state, diagnosis of bronchopneumonia and his decision to refuse treatment meant that his condition was terminal. When a serious medical condition will not respond to active treatment, or such treatment is refused, it is 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. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

39. On 10 June, the man's health had deteriorated to such an extent that a 'do not resuscitate' notice (DNR) was put in place. A doctor discussed this with the man and explained the implications. The man confirmed that he did not wish to be resuscitated in the event of cardiac or respiratory arrest. There was no formal end of life care plan.

40. A nurse reviewed the man on 26 June. She decided that despite his poor health he did not meet the criteria for an end of life pathway for the dying as he did not yet appear to be in the last hours and days of his life.

41. On 1 July, the nurse requested that an end of life pathway be started for the man, and that his medication should be prescribed in liquid form as he was struggling to swallow his tablets. A doctor reviewed the man at 2.35pm that day. He agreed with the nurse that the man was nearing the last few days of life but he wanted to take advice from another doctor or the palliative care team at the local hospice before implementing an end of life pathway for the dying.

42. Later that afternoon, the nurse spoke to staff at St Catherine's Hospice, Preston and they advised that beginning an end of life pathway would now be appropriate. However, no decision was made to implement a pathway for the dying at that time.

43. A prison doctor, saw the man at 7.49pm and changed his medication to liquid oramorph (a strong opiate painkiller). He requested that another doctor should review the man's condition the next morning.

44. On 2 July, notes made by a nurse later in the day indicate that the doctor reviewed the man sometime that day (the time was not recorded) and decided that he did not need to be started on an end of life pathway for the dying at that time. The doctor provided a statement in which he said that he remembered discussing his care with a nurse that morning but did not actually

see the man. The doctor said that he did not make an entry in the man's medical record because he had not examined him.

45. A nurse saw the man at about 3.00pm and noticed that his condition had deteriorated significantly from the morning. There was no doctor available at the time as the doctor had been called away. The nurses tried, to contact a doctor at HMP Wymott to prescribe additional palliative medication but were unable to do so.

46. At 3.49pm, the nurses on duty began to manage the man on an end of life pathway for the dying. Although the nurses were unable to issue further palliative medication without a doctor's authority, the records show that the man remained comfortable and pain free. Nurses were with the man when he died at 4.50pm.

47. A nurse told us that staff had found the situation with the man stressful as no palliative measures such as anticipatory medication for end of life symptom control had been considered before the end of life pathway was implemented just an hour before the man died. She said that she had not received any palliative care training despite working in the inpatient unit. We found that not all healthcare staff fully understood the use of end of life pathways.

48. The clinical reviewer commented that:

> "The man was a poorly man who had complex health needs. He received a great deal of input from medical and nursing staff. The medical staff consulted with the appropriate medical teams to provide the man with the most appropriate and current treatments".

49. We are satisfied that the man received appropriate care and the clinical reviewer considered that the man received treatment that was equivalent to, if not better than the care he would have received in the community. The clinical reviewer considered that on this occasion the delay in beginning an end of life pathway for the dying did not have a detrimental effect on the man's comfort. However, it is a concern that doctors at Preston seemed reluctant to implement an end of life pathway even after palliative care staff at St Catherine's Hospice advised on 1 July that it was an appropriate time. There appears to be a general need for training in palliative and end of lifer care for healthcare staff at Preston. We make the following recommendation:

The Head of Healthcare at Preston should ensure that nurses working in the inpatient care unit receive appropriate end of life and palliative care training and that guidance is issued to medical staff on when it is appropriate to begin an end of life pathway for the dying.

The man's location

50. The man was located in the inpatient health care unit at HMP Manchester when he was first sentenced. At Wymott, apart from his first night when the

prison was unaware of his needs, he lived on the elderly persons wing, where full time carers assisted with his social care needs.

51. After his lower leg amputation, the man moved to the inpatient unit at HMP Preston for a period of rehabilitation. He received full care for his personal and hygiene needs. A walking frame, wheel chair and hoist for lifting him out of bed were provided.

52. The man was admitted to hospital a number of times before his death. His reduced appetite led to weight loss and the risk of malnutrition. While in hospital, the man completed a preferred priorities of care document (a tool used for discussing and recording end of life care wishes). A move to a local hospice was considered but the man asked to go back to the prison, so he returned to the Preston inpatient unit.

53. We are satisfied that appropriate consideration was given to the man's location and where his physical and medical needs could best be managed.

Liaison with the man's family

54. Staff at Wymott informed the man's son when he was admitted to hospital for the amputation of his lower leg in January 2013. On 22 June, after a further admission to hospital, staff at Preston attempted to contact the man's son but were initially unsuccessful. On 24 June, the man's son called the prison and spoke to the inpatient healthcare staff.

55. The man's son visited his father on 28 June and was informed of his deteriorating health by the inpatient manager, who explained that additional visits could be facilitated. The prison chaplain was identified as a point of contact for the man's family.

56. On 2 July at about 2.55pm, the chaplain contacted the man's son and informed him of the man's rapid deterioration. Sadly, the man died before his son arrived at the prison.

57. A prison family liaison officer from Wymott contacted the man's family the next day to offer support. The family liaison officer and an operational manager visited the man's family on 5 July. Financial assistance towards funeral expenses was offered, in line with national guidance.

58. We are satisfied that there was appropriate liaison with the man's family during his illness and after his death.

Compassionate release

59. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons, usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

Staff at Wymott made initial enquiries in April 2013 about the likelihood of compassionate release. They discussed the possibility of an application for compassionate release with the man but he made it clear that he wanted to remain in prison. We are satisfied that this was given appropriate consideration.

Restraints, security and escorts

66. When prisoners have to travel outside prison to a hospital or hospice a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

67. 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 based on a risk assessment which considers the risk of escape, the risk to the public and also takes into account factors such as the prisoners' 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 serous medical condition. The judgement indicated that medical opinion regarding the prisoners' 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.

68. The man was admitted to hospital five times from Preston by emergency ambulance and each time he was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Although the man was at Preston, subsequent escorts were provided by Wymott as the man was regarded as still a Wymott prisoner. Each time he left Preston an emergency risk assessment concluded that the man should be restrained. There was little information from healthcare staff and the overall level of risk was not completed.

69. On each occasion, the Governor of Wymott reviewed the escort arrangements the next day and decided that due to the man's ill health he should be released on temporary licence, escorted by one officer. This meant that no restraints were used but an escort was maintained in case of public protection concerns.

70. While the use of restraint for the first emergency admission might have been understandable (if difficult to justify taking into account his health and mobility) it is hard to see why restraints continued to be used after previous decisions had been made that the man's risk was such that he should be released on temporary licence. The man was bed-bound, immobile and extremely frail and we do not consider that the use of restraints was justified by properly

considered risk assessments. It would have been sensible for both prisons to have anticipated future hospital admissions and to have agreed his level of risk, which was evidently low, to allow a consistent approach rather than relying on emergency assessments each time. We make the following recommendation:

The Governors of Preston and Wymott should ensure that the use of restraints for hospital escorts reflects the prisoners' actual risk at the time taking into account the prisoner's health and mobility.

RECOMMENDATIONS

1. The Head of Healthcare at Preston should ensure that all nursing staff working on the inpatient care unit receives appropriate palliative care training and that guidance is issued to all medical staff on when it is appropriate to begin an end of life pathway for the dying.

2. The Governors of Preston and Wymott should ensure that the use of restraints for hospital escorts reflects the prisoners' actual risk at the time taking into account the prisoner's health and mobility.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare at Preston should (1) ensure that all nursing staff working on the inpatient care unit receives appropriate palliative care training and (2) that guidance is issued to all medical staff on when it is appropriate to begin an end of life pathway for the dying.	Accepted	(1) All nursing staff working on the inpatient care unit have now received appropriate palliative care training and a rolling programme will continue. The palliative care lead continues to ensure nursing staff receive relevant updates regarding end of life care planning / commencement. Recently this has included input on outreach from St Catherine's Hospice and the local cancer network. (2) Guidance is contained within the local policy for end of life care. This has been reissued to medical staff and discussed at the local prison GP forum. It remains guidance and therefore it is at the doctor's discretion.	Completed Head of Healthcare Completed Head of Healthcare	
2	The Governors of Preston and Wymott should ensure that the use of restraints for hospital escorts reflects the prisoners' actual risk at the time taking	Accepted	Restraints will be applied or removed taking into account the prisoner's mobility and health at the time and dependant on the information	Completed Governing Governor	

	into account the prisoner's health and mobility.		received from medical staff. This is a dynamic risk assessment and when the circumstances are reported to have changed it will be reviewed.		