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 in March 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 chronic myeloid leukaemia and end stage kidney failure in March at HMP Preston. He was 84 years old. I offer my condolences to his family and friends.

A clinical review of the medical care the man received at Wymott and Preston prisons was carried out. Both prisons cooperated fully with the investigation.

The man was serving a life sentence and had been at HMP Wymott since June 2000. He was diagnosed with acute kidney failure in November 2011 and had dialysis three times a week at hospital. After abnormal blood test results he had a bone marrow biopsy on 29 December and was diagnosed with acute myeloid leukaemia for which he received treatment. He spent some months in the healthcare centre at Preston in the summer of 2012, because of the possibility of infection arising from dialysis. He then returned to Wymott. His condition steadily deteriorated over the next two years.

On 1 March 2014, the man decided to refuse all active treatment. After that his condition deteriorated rapidly and he was transferred to the healthcare unit at HMP Preston for end of life care. He died at 7.40pm the next day.

The clinical reviewer concludes that the overall standard of clinical care the man received was equal to that he could have expected in the community. While there were some examples of good practice in the support provided at both prisons, there were no formal care plans in place at Wymott. I am also concerned that he appears to have been restrained for hospital visits, including while undergoing dialysis, despite being elderly, frail and in very poor health. This is a matter I have raised with the prison before and the Governor needs to ensure that staff fully understand their legal obligation in relation to the use of restraints for seriously ill prisoners undergoing life saving treatment 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 2014**

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SUMMARY

1. The man was serving a life sentence and had been at HMP Wymott since June 2000. He transferred to HMP Preston the day before his death. Records show he did not have any significant health concerns until November 2011.

2. On 24 November 2011, the man reported breathlessness, a tight chest and an increased thirst. A blood test showed he had a low red blood cell count and possible kidney failure. A prison GP referred him to the hospital for review. He remained in hospital for three weeks, during which he was diagnosed with acute kidney failure, but refused dialysis.

3. After abnormal blood test results, the man had a bone marrow biopsy on 29 December. He was diagnosed with acute myeloid leukaemia and prescribed daily medication.

4. At an appointment with his renal consultant on 23 March 2012, the man said he now wanted to have dialysis and was put on the waiting list. On 31 May, he started dialysis and attended three times a week at the hospital. He was noted to be frail and weak and doctors told him that his prognosis was around two years.

5. Over the next two years, the man continued with dialysis and treatment for leukaemia. He remained stable and had no other significant health concerns.

6. On 1 March 2014, the man said that he had been thinking for a long time about his quality of life and decided to stop all active treatment. Healthcare staff discussed this decision and the implications with him and supported him. His condition deteriorated rapidly and he was transferred to the healthcare at HMP Preston for end of life care. He died at Preston the following evening.

7. The clinical reviewer concludes that, overall, the level of clinical care the man received was equal to that he could have expected in the community. There was some good practice, such as good communication and transfer of medications between the two prisons. However, he did not have a care plan while at Wymott, despite his age and conditions. Risk assessments for escorts to hospital did not take into account his frail condition and restraints were used without proper justification. We are concerned that they remained in place while he was receiving dialysis treatment. We make two recommendations.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She wrote to the Governor about the preliminary findings of the investigation.

10. NHS England commissioned a clinical reviewer to assess the man's clinical care at Wymott and Preston.

11. We informed HM Coroner for Preston and West Lancashire District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin and a family member to explain the investigation. They did not have any specific concerns about his treatment but wanted to know what happened during his time in prison.

13. The man's family received a copy of the draft report. They commented that his overall care was not equal to what he could have expected in the community and so the report has been amended to say that the *clinical* care he received was equal. They also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

14. 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 escorts, liaison with his next of kin, and whether compassionate release was considered.

HMP PRESTON

15. HMP Preston is a local prison holding up to 842 adult men. Health services are provided by Lancashire Care Foundation Trust. There is an inpatient unit for up to 30 prisoners which is used as a regional facility. Inpatients remain the responsibility of their original prison for all aspects except healthcare.

HM Inspectorate of Prisons

16. The last inspection of HMP Preston was in April 2012. Inspectors found that an appropriate range of health services were provided. Primary care services had improved and inpatient services were satisfactory.

Independent Monitoring Board

17. Each prison 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 recent annual report for 2013, the IMB noted that the healthcare department at Preston appeared very effective.

Previous deaths at HMP Preston

18. The man was the ninth prisoner to die of natural causes at HMP Preston since the beginning of 2013. Preston has a regional inpatient service which takes prisoners with complex health needs and who need end of life care from other prisons in the area.

HMP WYMOTT

19. HMP Wymott is a category C prison holding over 1,100 adult men. Healthcare services are commissioned and provided by NHS Central Lancashire. A private company provides GP services. There are no inpatient beds, but there is nursing cover 24 hours a day.

HM Inspectorate of Prisons

20. The last inspection of HMP Wymott was in November 2011. The Inspectorate noted that healthcare staff were well integrated into the prison but were critical of the long wait experienced by some prisoners who wanted to see a GP.

Independent Monitoring Board

21. In their 2012/13 annual report, the IMB noted their concern about the inconsistent provision of GP services. Although urgent cases were seen promptly, there appeared to have been an increase in waiting times for non-urgent appointments.

Previous recommendations

22. We have made previous recommendations to Wymott about escort risk assessments and the inappropriate use of restraints for elderly and infirm prisoners.

ISSUES

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

23. The man was sentenced to life imprisonment in February 1969 and had been at HMP Wymott since June 2000. He did not have any significant contact with healthcare staff until November 2011.

24. A nurse examined the man on 24 November 2011. He was breathless, his chest was tight and he said he had an increased thirst. She noted that he looked jaundiced and dehydrated. She noted that he was underweight for his height. His blood pressure was within normal range. She carried out an ECG test which the doctor reviewed. The results were not in his medical records.

25. On 25 November, the man had a blood test, which showed he had a low haemoglobin count (haemoglobin is the part of the red blood cell that carries oxygen around the body) and possible kidney failure. Another ECG was recorded as normal. Because of the blood test results, a doctor sent him to hospital the same day for review.

26. The man was admitted and spent three weeks in hospital. Doctors told him that he had acute kidney failure and would need dialysis. However, he declined any active treatment. His discharge letter noted that he had had a heart attack in hospital and that blood tests had shown raised levels of white blood cells (which can be a sign of infection or leukaemia) and potassium (a result of kidney failure). He had an outpatient appointment for a bone marrow biopsy. He was advised about keeping to a low salt diet and returned to Wymott on 15 December.

27. On 29 December, the man had a bone marrow biopsy. He had regular blood tests to monitor his kidney function and on 23 January 2012, his results were noted as abnormal. He did not attend for a check the next day and his blood was next checked on 26 January. His medical record noted that he was aware his kidney function was worsening, but he refused dialysis and said he felt well. The results of the blood tests were received that night and did not require any action.

28. On 1 February, the oncology department at the hospital telephoned healthcare at Wymott and explained that the man needed a blood transfusion and he went to hospital for the transfusion on 3 February. A haematology consultant explained that the results of the bone marrow biopsy revealed he had acute myeloid leukaemia and prescribed daily medication to stop cancer cells growing. The consultant noted that the man understood the risks of side effects of the treatment, and wanted to continue. He gave him information about leukaemia and specialist nurses and the chemotherapy support team offered support. He attended appointments with the consultant every two weeks to review his progress.

29. The clinical reviewer is satisfied that the man's symptoms were investigated promptly and he was appropriately referred for investigative tests. He was

informed of his diagnosis while he was in hospital. He had a good understanding of his conditions and was well supported.

The man's medical treatment

2012

30. On 6 February 2012, the man was taken to hospital for a blood transfusion as his haemoglobin count had dropped and his potassium level was high. He remained in hospital but still refused dialysis. The hospital renal dietician explained what he should eat. He had a good understanding of the low salt diet needed. However, he did not follow this.

31. The man was discharged back to Wymott on 11 February. A nurse noted that he looked well, had no concerns and had appropriate medication. He had a weekly injection to help the production of red blood cells. On 23 February, the haematology consultant saw him at the hospital. He noted that he was reasonably well in himself and his haemoglobin count had increased.

32. On 14 March, the man's blood test results showed he had low calcium and magnesium and anaemia. He was admitted to hospital. While in hospital he had two blood transfusions. The consultant examined him and noted he had no chest pain and was not short of breath. His cancer medication was stopped for three weeks while his kidney condition stabilised. He was discharged to Wymott on 20 March and noted to be fine, but frail.

33. A renal consultant saw the man at hospital on 23 March. He had changed his mind about dialysis and was put on the waiting list. On 4 April, his blood test results showed a high level of potassium and he was admitted to hospital. He had several blood transfusions and the haematology consultant re-prescribed his cancer medication. He went back to Wymott on 17 April. On 25 April, he was admitted to hospital because of high potassium levels and remained there for two days.

34. There were no formal care plans to monitor the man's condition at Wymott. However, healthcare staff used charts to monitor his food and fluid intake and kept a record of his general condition and any significant information from hospital appointments or admissions.

35. On 8 May, the man was admitted to hospital again after abnormal blood tests results. He was given fluids through an intravenous line and had a blood transfusion. He was discharged to Wymott on 13 May. On 14 May, a prison GP reviewed him and noted that his condition had deteriorated and that he was on the waiting list for dialysis. He said he was feeling unwell and had difficulty with daily tasks, so arrangements were made for carers to give him additional support.

36. On 15 April, the man was being taken to hospital by taxi when he had a fit and vomited blood. An ambulance then took him to the hospital where neurology

and haematology consultants reviewed him. He remained in hospital until 17 May.

37. The man's first dialysis treatment was booked for 28 May, but the letter did not arrive at the prison in time and he missed his appointment. On 29 May, he was admitted to hospital after an appointment with the haematology consultant. He was stable, but very unwell. The consultant reduced his medication while his condition stabilised. On 31 May, he had his first dialysis session and then attended dialysis twice a week.

38. Wymott's palliative care lead visited the man in hospital on 1 June. She recorded he was frail, but alert. He had a good appetite and was prescribed high calorie supplement drinks to help maintain his weight. She discussed his diagnosis and prognosis with him and he was aware that his life expectancy was not long. He requested that a do not attempt cardiopulmonary resuscitation (DNACPR) order was put in place. (A DNACPR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)

39. The man had an open dialysis line in his left arm, which was at risk of infection and required 24 hour nursing care, so he was discharged from hospital to HMP Preston on 7 June. Healthcare staff at Wymott contacted staff at Preston about his medication and appointments at the hospital and provided a full handover. Preston implemented care plans to cover his attendance at hospital, personal hygiene and care of the dialysis line. A prison GP discussed the DNACPR order with him. He said he wanted it to continue and was aware of the implications.

40. On 21 June, a member of the healthcare team at Preston encouraged him to think about future care and his end of life preferences. The man said he was happy with his care. A nurse manager also spoke at length with him. He told her that his renal consultant had explained that he had about two years left to live and he was relieved that he had a prognosis. He said he did not want to go back to Wymott as he was being well cared for at Preston. He said he would prefer to die in a hospice or hospital.

41. The nurse manager spoke to the man again on 10 July. He said that he felt better and thought this was due to the dialysis. He continued to be cared for at Preston. On 5 September, the haematology consultant saw him and explained that his white blood cell count was still abnormal, but his haemoglobin had improved. He transferred back to Wymott on 20 September. The palliative care lead assessed him and noted he was independent in his hygiene and dressing, but needed help with keeping his cell clean.

42. On 10 October, the haematology consultant saw the man and explained that the cancer medication had not had an impact on his leukaemia. He did not have any concerns or complications with his treatment regime. He coped well

on his wing and carers supported him well. He continued to have dialysis twice a week and was reasonably well despite his medical conditions.

2013

43. On 2 April 2013, the man's cancer medication was increased as there had still not been a positive response to the treatment. On 17 July, the haematology consultant increased the medication again and sent a letter to healthcare staff at the prison outlining the change. This was not actioned until after the man's next appointment with him on 13 August.

44. The consultant next saw the man on 22 November. He said he felt increasingly tired and had started to experience shortness of breath. His haemoglobin levels had fallen and a further review was booked. He returned for his review on 21 December but no blood samples had been taken and so the test was booked for his next dialysis appointment. He was apparently well in himself. There is no further significant information in his medical record for the next few months.

2014

45. On 1 March 2014, the man told a nurse that he had run out of his prescriptions. The nurse obtained additional medication for him but when she went back to his cell, he handed her all his medication and said he had decided that he did not want any further active treatment. She asked the palliative care lead to speak to him in her capacity as the older persons lead.

46. The palliative care lead went to see the man the next day. He said he had been thinking about his medical situation for around eight months and felt that his quality of life was poor and he did not wish to prolong it. He understood the consequences and knew that, although he felt well, he could quickly deteriorate. He signed a disclaimer to stop all active treatment and to receive only symptomatic relief. The prison doctors and a psychiatrist all considered he had the mental capacity to make this decision.

47. A doctor reviewed the man on 3 March. The doctor reiterated the life threatening consequences of his decision, but he said he still did not want any treatment. The doctor explained the symptoms he might experience and said he would be made as comfortable as possible. He agreed to a referral to a hospice for supportive measures and confirmed that he still did not want to be resuscitated.

48. By 9 March, the man's condition had deteriorated and he was eating very little. At 9.00am on 10 March, his carers reported that he did not appear to understand instructions any longer. He was still taking fluid, but this was now through a straw. The palliative care lead was concerned about his condition as he had deteriorated very quickly. He said he was not in pain and agreed to move to the healthcare unit at Preston that evening.

49. Healthcare staff at Preston implemented an end of life care plan to support the man and his door was left open to ensure healthcare staff had unrestricted access to provide medical care.

50. Later, the man's breathing was shallow and his pulse weak. His eyes were closed and he shook his head when asked if he was in pain. At 4.45pm, he became unresponsive, but did not appear to be in any pain or agitated. At 7.15pm, he became agitated and he was given a sedative. He died peacefully at 7.40pm.

51. The coroner gave the cause of death as chronic myeloid leukaemia and end stage kidney failure.

52. We are satisfied that the man was informed of his treatment options and was well supported by healthcare staff. He was able to attend numerous outpatient appointments and there was good sharing of information between those responsible for his care. However the clinical reviewer comments, that a care plan should have been implemented at Wymott for a man of his age and condition to help ensure continuity of care. We make the following recommendation:

The Head of Healthcare at Wymott should ensure that care plans are implemented for all prisoners with chronic and/or life limiting conditions

The man's location

53. The man was transferred to a specialist wing for older and disabled prisoners at Wymott shortly after his diagnosis of kidney failure and leukaemia. The wing is a 65 bed unit, which has special facilities for elderly and disabled prisoners. There is close involvement from Age Concern staff and social care workers support prisoners with daily tasks.

54. In June 2012, the man received dialysis through an open line and therefore it was not suitable for him to return to the wing due to the risk of infection. He was appropriately transferred to the healthcare centre at HMP Preston on 7 June.

55. After this medical staff discussed the man's future treatment and agreed that after he had a fistula fitted he would be transferred back to Wymott. He went back to Wymott on 20 September and had a carer to help him clean his cell and assist with daily tasks, such as collecting meals.

56. On 10 March, the man moved to Preston. We are satisfied that his location was suitable throughout his illness and was reviewed appropriately according to his changing needs.

Restraints, security and escorts

57. 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.

58. Wymott was unable to provide us with all the risk assessments for the man's outpatient hospital appointments and admissions. It is apparent from the available risk assessments that he was considered a low risk to the public, hospital staff, of hostage taking and of outside assistance to escape and a medium risk to children. Entries were made by healthcare staff, such as "gets breathless walking distances and needs a wheelchair". However, healthcare staff also stated that he still had the ability to escape. It is not clear how they reached that conclusion. In the security section, it was often noted that the restraints were applied in accordance with the local security strategy. For his hospital appointments and admissions throughout 2013 and into 2014, an escort chain was used (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and he was accompanied by two officers. There is no evidence that the escort chain was removed for dialysis treatment.

59. The local security strategy clearly states that "restraints should be removed unless there is a risk of escape". From the risk assessments we have seen, there is some evidence that healthcare staff considered the man's medical condition and its impact on his risk of escape but some of the conclusions reached appear to be incompatible with his condition. He had chronic kidney failure and leukaemia, was breathless on exertion and needed to use a wheelchair. He was over eighty and accompanied by two prison officers at all times. It is difficult to see how he would have had the ability or opportunity to escape or reoffend. We are particularly concerned that there is no record that the escort chain was removed when he was receiving dialysis treatment. This is inappropriate and not consistent with the 2007 High Court judgement. We have raised the issue of the need to ensure appropriate risk assessment with HMP Wymott before. Although our previous recommendations have been accepted, and action plans submitted, it is apparent that very sick prisoners, such as he, are still restrained without a satisfactory and comprehensive risk assessment. We again make the following recommendation:

The Governor of Wymott 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 next of kin

60. An operational manager spoke to the man on 5 March 2014 about his decision to stop active treatment. She asked him if he would like his family or visitors to be informed of his decision and poor health. He said that he did not want anyone to be notified.

61. The prison appointed a family liaison officer on 10 March after the man's condition became grave. He spoke to him about informing his family and next of kin of his death. He said he would like his nominated next of kin, a prison visitor, to act as Executor of his Will and did not have any preference about funeral arrangements. He asked that a friend he maintained contact with to be informed after his death.

62. As the man's nominated next of kin lived some distance from HMP Preston, the family liaison officer contacted HMP Isle of Wight, a nearby prison to his next of kin, to ask them to inform her of his deteriorating condition. Later that day, he learnt that the man's death was imminent and he tried to contact HMP Isle of Wight to update them and ask for the next of kin to be informed urgently. He was unable to speak to anyone who could tell him whether they had contacted her. He tried to telephone the man's friend three times, but was unable to make contact.

63. At 9.30am on 12 March, the family liaison officer telephoned Gosport Police, who broke the news of the man's death to his next of kin. She contacted the family liaison officer soon after.

64. The prison arranged and paid for the man's funeral, in line with national guidelines. The funeral was held on 20 March and staff attended. We are satisfied that the liaison between the prison and the man's next of kin was appropriate and in line with his wishes.

Compassionate release

65. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

66. During a discussion with the nurse manager in June 2012, the man said he wanted to make an application for compassionate release and instructed his solicitor to start the application. At the time he had a formal prognosis of less than two years to live, but a definitive timescale could not be given. As a result, he did not apply.

67. On 3 March 2014, a doctor discussed the compassionate release process with the man after he decided to stop active treatment. He said he did not want to apply for compassionate release now as he did not have a support network and did not have anywhere to go. We are satisfied that the compassionate release process was appropriately considered and discussed with him.

RECOMMENDATIONS

1. The Head of Healthcare at Wymott should ensure that care plans are implemented for all prisoners with chronic and/or life limiting conditions.

2. The Governor of Wymott 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

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare at Wymott should ensure that care plans are implemented for all prisoners with chronic and/or life limiting conditions.	Accepted	The Healthcare department are currently reviewing the care pathway at HMP Wymott and the four other Lancashire prisons. The aim is for all prisoners over 60 years old to have an initial health and social care assessment (OSHCAP) completed by a registered nurse. This will identify all those with social care needs, chronic and/or life limiting conditions and any needs that may be required to be added to a care plan. The implementation of the pathway has already started at HMP Wymott through the prison's older persons' lead nurse.	October 2014 Mental Health Manager HMP Wymott
2	The Governor of Wymott 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.	Accepted	Healthcare staff now provide details of each prisoner's physical and mental condition prior to escorts taking place. Medical opinion is then taken into account when deciding the level of restraints that should be used. Custodial Managers conduct daily bed watch checks and review the level of restraints that are in place. Staff conducting the escort/bed watch will contact the prison to ask for the restraints to be	Completed The Governor HMP Wymott

			removed if the medical condition warrants it at any point.	