A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman in January 2014, while in the custody of HMP and YOI Low Newton

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 woman from liver disease in January 2014, while in the custody of HMP Low Newton. She was 43 years old. I offer my condolences to the woman's family and friends.

The investigation was carried out by an investigator. Three clinical reviewers reviewed the clinical care the woman received in prison. Low Newton cooperated fully with the investigation.

In 2011, the woman was sentenced to six years in prison and sent to HMP Styal. She had a long history of chronic drug and alcohol abuse. In June 2012, she transferred to Low Newton. In July, the prison doctor referred the woman urgently to a consultant after abnormal blood tests. Her condition deteriorated significantly and she remained in hospital until October. She was then discharged from hospital back to prison with a diagnosis of advanced liver disease, hepatitis C and cirrhosis.

After a further hospital admission in December, the woman returned to Low Newton in April 2013 for palliative care. Specialists from a Marie Curie hospice gave clinical advice. The woman's health gradually deteriorated over the following months. She moved to the hospice for end of life care on 31 December and died four days later.

It is unfortunate that the woman did not have a test for hepatitis C at Styal which might have identified her condition earlier, but the clinical reviewers conclude that the standard of healthcare she received was at least equal to that which she could have expected to receive in the community. I commend the high standard of palliative care that the woman received at Low Newton.

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

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SUMMARY

1. The woman was remanded to prison in March 2011 and sent to HMP Styal. In September 2011, she was sentenced to 6 years in prison for theft and false imprisonment and remained at Styal. The woman had been in prison before and had a long history of chronic drug and alcohol addiction.

2. In June 2012, the woman transferred to HMP Low Newton. In July, she was urgently admitted to hospital after abnormal blood test results. Her health worsened and she remained in hospital until October. She was discharged back to prison with a diagnosis of advanced liver disease and hepatitis C with cirrhosis. Healthcare staff reviewed the woman every day after she returned to the prison.

3. The woman was re-admitted to hospital in December 2012 because of increased oedema (fluid retention). She remained in hospital and was told her condition was not considered curable. In March 2013, the woman transferred to a local hospice for specialist symptom management. She returned to Low Newton in April and received palliative care at the prison.

4. In December, healthcare staff became increasingly concerned about the woman's condition. She transferred to the hospice for assessment on 10 December. The woman came back to Low Newton on 27 December, but returned to the hospice four days later after her condition deteriorated again. She received end of life care at the hospice, and died on 4 January 2014.

5. The clinical review found that there was a missed opportunity at Styal for blood-borne virus screening which might have indicated sooner that the woman had hepatitis C and this might possibly have led to earlier investigations. However, overall, the clinical reviewers were satisfied that the woman received a high standard of care in prison, with effective multidisciplinary support at the end of her life. We make one recommendation about blood-borne virus screening.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Low Newton informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

7. NHS England commissioned three clinical reviewers to review the woman's clinical care in prison.

8. The investigator obtained copies of the woman's prison medical records and relevant extracts from her prison record. He and the clinical reviewers interviewed six members of staff at Low Newton on 3 March 2014. The investigator wrote to the Governor with initial feedback about the investigation.

9. We informed HM Coroner for Newcastle, Tyne and Wear district of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the woman's mother, her nominated next of kin, to explain the investigation. She did not raise any issues for the investigation to consider.

11. The investigation has assessed the main issues involved in the woman's care, including her diagnosis and treatment, whether appropriate palliative care was provided, her location, security arrangements for hospital escorts, liaison with her family and whether compassionate release was considered.

12. The woman's family were informed the draft report was available, but did not wish to receive a copy or make a comment.

13. The service also received a copy of the draft report. Their response to our recommendations and action plan is included at page 15 of this report.

HMP NEWTON

14. HMP Low Newton is a women's prison near Durham. Care UK provides healthcare services at the prison. The healthcare unit has inpatient facilities with 24 hour nursing cover, and GP services are available during the week, with on-call cover at night and at weekends.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Low Newton in April 2012, found that health services at the prison were well established. Most women rated the overall quality of services as good or very good. There was some lack of clarity about management of the inpatient unit and little individual mental health counselling was provided.

Independent Monitoring Board

16. 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 published report for the year to February 2012, the IMB reported that staff demonstrated genuine concern for the welfare of women and that the healthcare staff coped admirably for prolonged periods with mentally ill and volatile women.

Previous deaths at HMP Low Newton

17. The woman was the third prisoner to die in the custody of Low Newton since 2010, and the first from natural causes. There were no similarities with previous cases.

ISSUES

The diagnosis of the woman's terminal illness and informing her of her condition

18. The woman was remanded to HMP Styal in March 2011 (and was sentenced in September 2011). She had a history of chronic alcohol and drug abuse, and was prescribed methadone. The woman had circulatory problems related to substance abuse. She also suffered from depression. During initial health screenings, staff offered the woman blood-borne virus screening (BBV screening, for the three most common blood-borne viruses, HIV, Hepatitis B and Hepatitis C). Although the woman agreed to screening, there is no record that this was carried out while she was at Styal.

19. The woman had frequent contact with healthcare staff at Styal for treatments and medication. In May 2012, she was admitted to hospital twice after she reported feeling unwell. The diagnosis on discharge was a blood infection.

20. The woman transferred to Low Newton on 28 June 2012. She was offered screening for hepatitis C, but it is not clear if she agreed. The woman complained of pain in her legs and back shortly afterwards and, on 11 July, a nurse examined the woman who looked jaundiced. The nurse was unable to take blood because of poor vein access. A prison GP reviewed the woman on 12 July and took a blood sample.

21. The results were received the next day and showed severe jaundice, low levels of albumin (protein made by the liver) and hepatitis C antibodies. The woman was admitted to the University Hospital of North Durham later that day. Her health deteriorated significantly and she remained in hospital under the care of consultants until 31 October. She was discharged to Low Newton with a diagnosis of advanced liver disease, hepatitis C with cirrhosis and multiple infections. She required daily input from healthcare staff, who liaised regularly with the hospital about her care.

22. We are satisfied that healthcare staff at Low Newton referred the woman quickly to hospital after the abnormal blood results. Hospital consultants informed of her life limiting condition. When she arrived at Low Newton, it appears the woman's liver disease was already advanced but undiagnosed.

23. The woman had accepted the offer of BBV testing at Styal but it appears this was never carried out. The reviewers concluded that with earlier blood tests, her hepatitis C might have become apparent sooner, with the opportunity to refer her to specialist services. While her liver disease was well advanced when she arrived at Low Newton, it is unclear what was done about BBV testing. From April 2014, new guidance about opt-out BBV testing came into operation. We make the following recommendation:

    The Heads of Healthcare at Styal and Low Newton should ensure that opt-out blood-borne virus screening is introduced in line with national guidelines.

The woman's medical treatment

24. On 31 October, a nurse examined the woman when she returned to Low Newton and was admitted to the prison's inpatient unit. A prison GP reviewed the woman later that day and prescribed medication, as the hospital consultants had directed.

25. A mental health nurse assessed the woman on 2 November after she reported feeling depressed. They discussed her recent health problems and the nurse offered to arrange visits from other prisoners to the inpatient unit. The records show that the woman had frequent mental health reviews at Low Newton.

26. Healthcare staff continued to review the woman daily. She suffered from increasing oedema and staff often had difficulty taking blood.

27. On 4 December a consultant physician reviewed the woman at an out-patient clinic at the Royal Victoria Infirmary in Newcastle. The consultant thought that the woman's liver condition had improved, but he was concerned about her oedema and kidney function and admitted her to hospital for symptom management. Prison healthcare staff had frequent contact with the consultants and attended multidisciplinary team meetings while the woman was in hospital.

28. On 9 January 2013, at a multidisciplinary meeting at the Royal Victoria Infirmary, the consultant told prison healthcare staff that the woman would continue to receive antibiotics, but no surgical treatment was planned because of her advanced liver disease. This would be reviewed if her condition improved. The woman remained in hospital for symptom management and had surgery on a leg wound.

29. On 14 February, a multidisciplinary team discussed the woman's illness and treatment options with her. The consultant told her that surgical intervention was not possible. Her condition was not curable and she would require palliative care. The consultant discussed resuscitation options with the woman. She said she intended to sign a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order when the time was right. 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.

30. Staff from Low Newton continued to have frequent contact with the woman, and attended multidisciplinary meetings at the hospital to plan her future care. On 18 March, the Marie Curie hospice in Newcastle agreed to accept the woman for a period of symptom management and end of life care when required. The woman moved to the hospice on 20 March.

31. The woman returned to the healthcare unit at Low Newton on 3 April. At the hospice she had agreed and signed advanced directives to refuse future treatment and a DNACPR order and there were appropriate plans for her

care. These were recorded on SystmOne (the electronic medical record) and placed on file in the healthcare unit for staff handovers. The GP discussed her decisions with the woman when she returned to the prison and updated her prescriptions.

32. A Marie Curie specialist palliative care nurse, and a MacMillan palliative specialist reviewed the woman weekly at Low Newton. They provided support and guidance to the woman, healthcare staff and custodial staff. The specialists had frequent input into discussions about the woman's care and treatment, particularly in relation to pain relief during the course of her illness. Healthcare staff continued to review the woman daily and treated her leg wound.

33. The woman experienced ongoing pain in her back and legs which was managed with painkillers including oramorph (oral morphine) and pregabalin (anticonvulsant often used for pain relief). Healthcare staff reviewed her medication frequently and adjusted the woman's pain management regime when she reported being in pain. Records show that she was able to obtain pain relief quickly when she needed it.

34. As the woman's disease progressed, she suffered increased oedema, and her mobility decreased. She became drowsier, and fell in her cell a number of times. She was given an emergency alarm to wear on her wrist, and a wheelchair and walking sticks to help her get about. A nursing manager told us that the woman was reluctant to use these and wanted to remain independent.

35. In August, a multidisciplinary meeting discussed the possibility of hospice day care, but decided that the woman could not cope with frequent journeys to and from prison. The meeting agreed to use the hospice for symptom assessment and support when required. On 3 October, the woman transferred to the hospice for a week. Specialists reviewed and adjusted her pain relief, and advised about caring for her ongoing leg wound.

36. On 7 December, healthcare staff noted a further deterioration in the woman's condition. The nursing manager contacted hospice staff for advice, who agreed that the woman should be admitted for assessment when a bed became available. On 10 December, the woman's condition deteriorated further and she transferred to the hospice.

37. The woman's condition stabilised while she was in the hospice and she returned to Low Newton on 27 December after her medication had been adjusted. On the morning of 31 December, the woman's condition deteriorated further and a doctor agreed with staff at the hospice that the woman should transfer there for end of life care. Later that afternoon, the woman went to the hospice by ambulance, accompanied by a healthcare support worker. The woman received end of life care at the hospice and died on 4 January 2014.

38. The clinical reviewers concluded that the woman's care and treatment in prison was at least equal to that which she would have received in the community. They noted that there was good communication between healthcare staff and outside specialists, and identified the woman's case as an example of effective multidisciplinary end of life care in prison. We agree that the woman received a high standard of palliative care in prison. She received good clinical and personal care from healthcare staff and the palliative specialists throughout her illness. Pain relief and symptom control were appropriately managed and frequently reviewed by specialists.

The woman's location

39. Before she was discharged from hospital back to the prison in April 2013, the woman spent two weeks at the Marie Curie hospice in Newcastle for symptom management and end of life care planning. The woman told the palliative care nurse that she wanted to die in a hospice, and the hospice agreed to accept the woman for end of life care.

40. When the woman returned to Low Newton on 3 April, she lived in the prison's inpatient healthcare unit in a cell close to the staff office. The cell was newly-refurbished, with a hospital bed. She was given a personal alarm to call for assistance. The prison operated an open-door policy during the day, allowing healthcare staff easy access to the cell.

41. The woman had a number of falls in her cell, often at night. A nurse told us that the woman preferred to sleep in her chair rather than bed, which contributed to this. He said that staff checked the woman frequently at night as she was often drowsy and susceptible to falls.

42. The woman remained in the unit, apart from two admissions to the hospice for symptom management in October and December 2013. She was admitted to the hospice for end of life care on 31 December.

43. We are satisfied that the woman had appropriate accommodation in the prison which met her needs. Staff recorded her preference to receive end of life hospice care early on in her illness and frequently reviewed this decision. Healthcare staff and specialists agreed to transfer the woman to the hospice when her symptoms suggested that she required end of life care. The clinical reviewers concluded that good communication between the woman's carers resulted in a successful transition to the hospice for end of life care.

Restraints, security and escorts

44. 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.

45. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and

based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

46. When the woman was admitted to hospital in July 2012, although unwell, she was mobile. She was restrained by 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) and escorted by two officers. While in hospital, the woman became critically ill. The prison granted release on temporary licence (ROTL). Restraints were removed and the staff escort was withdrawn until the woman's condition had stabilised.

47. On 5 December 2012, the woman was re-admitted to hospital with increased oedema. She was initially restrained by an escort chain and accompanied by two officers. On 10 December, the deputy governor, directed that the restraints should be removed when it became clear that the woman's health was deteriorating and she was likely to remain in hospital for some time. On 19 December, the Governor agreed she should be released on temporary licence for the duration of her hospital stay. The woman remained released on temporary licence until she returned to Low Newton in April 2013. Release on temporary licence was used for further hospice stays.

48. While it is not wholly clear that the risk assessment when the woman went to hospital in December 2012, fully took into account her health at the time, we are pleased to note that this decision was reviewed five days later and restraints were never used again. We are satisfied that this allowed the woman to receive appropriate and dignified treatment while in hospital and subsequently at the hospice.

Liaison with the woman's family

49. The woman was estranged from her family and had no direct contact with them during her illness.

50. A prison manager contacted the woman's mother, her nominated next of kin, in September 2012 when she was critically ill in hospital. The woman's mother said she did not want any further information about the woman's condition.

51. The records show that staff had frequent discussions with the woman about family contact during her illness. She spoke about her family, but she did not want to have contact.

52. On 31 December 2013, when the woman transferred to the hospice for end of life care another prison manager, informed the woman's mother who again said she did not want to receive any further information.

53. The police informed the woman's family of her death at the instruction of the Coroner. The Governor wrote a letter of condolence to the woman's mother,

who later contacted the prison and arranged for the return of the woman's possessions to her family. Low Newton arranged and paid for the funeral.

54. We are satisfied the woman's family was kept informed when her health deteriorated significantly.

Compassionate release

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

56. At a multidisciplinary meeting on 14 February 2013, the woman told staff that she intended to apply for release on compassionate grounds. However, there is no record of an application being submitted at that time.

57. On 6 March, staff involved in the woman's care discussed the possibility of early release. They noted that this could not be guaranteed and discussed the possibility of hospice care at the end of her life. On 21 May, the consultant gave the woman a likely prognosis of up to a year to live, but was unable to confirm this.

58. A multidisciplinary meeting on 8 August reviewed the woman's wish for compassionate release. It was noted that an accurate prognosis was difficult as the woman's clinical symptoms and appearance changed daily. The deputy governor said he would not support an application for release on compassionate grounds as the woman did not have an appropriate release address or any ties outside prison. He agreed that release on temporary licence would continue for hospice treatment and end of life care.

59. It does not appear that the woman met the criteria for early release on compassionate grounds and the nature of her illness meant that it was difficult for doctors to give an accurate prognosis of her life expectancy. However, we are satisfied that temporary release was used appropriately as an alterative.

RECOMMENDATION

The Heads of Healthcare at Styal and Low Newton should ensure that opt-out blood-borne virus screening is implemented in line with national guidelines.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Heads of Healthcare at Styal and Low Newton should ensure that opt-out blood-borne virus screening is implemented in line with national guidelines.	Accepted	Healthcare at establishments in the region including HMP/YOI Styal and HMP/YOI Low Newton are working with public health colleagues to improve existing pathways and develop a programme for implementation with timescales to comply with national guidelines regarding opt out blood borne virus screening. Implementation will proceed once the funds have been identified by the commissioners (NHS England). In the interim the establishments are developing guidelines and healthcare principles regarding the inter prison transfers of prisoners between HMP/YOI Styal, HMP/YOI Low Newton, HMP New Hall and HMP Askham Grange. These guidelines will lead to standardisation of procedures and improved communication, including information regarding blood borne virus screening.	Heads of Healthcare July 2014 Interim guidelines April 2015 National guidelines	