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 October 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 from throat cancer on 7 October 2013 at HMP Preston. He was 61 years old. I offer my condolences to the man's family and friends.

An investigator was appointed and a clinical reviewer reviewed the clinical care the man received at HMP Preston. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 2007 and transferred to HMP Garth later that year. In October 2012, the prison doctor referred the man urgently to an ear nose and throat consultant after he reported suffering from pain in his head and throat for three to four months. Tests indicated that he had throat cancer but the man refused any active treatment. In July 2013, he transferred to Preston Prison as HMP Garth did not have the full time healthcare cover he then needed. The man's health deteriorated further and he died at HMP Preston on 7 October.

I am satisfied that the man received an appropriate standard of health care at Garth and Preston. However, I do not consider that the use of restraints when the man was taken to hospital near the end of his life was justified by an appropriately considered risk assessment, a matter I have raised before with HMP Preston.

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

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SUMMARY

1. The man was sentenced to life imprisonment on 15 June 2007 and arrived at HMP Garth on 24 October 2007. He had a history of cardiovascular problems. He smoked heavily but refused help to give up.

2. In October 2012, the doctor referred the man urgently to an ear nose and throat consultant after he reported experiencing pain in his head and throat for three to four months. After tests, the man was diagnosed with carcinoma of the nasopharynx (throat cancer) in December. He refused active treatment. In February 2013, the man was diagnosed with secondary, symptom-free lung cancer and again refused treatment.

3. In July, the man was placed on an end of life care plan and moved to HMP Preston for 24 hour care after he had begun to experience problems swallowing. In August, had a feeding tube fitted. In September, the prison applied for the man to be released on compassionate grounds to a local hospice but the application was turned down as there was no clear prognosis at that stage.

4. At the beginning of October, the man's condition deteriorated very quickly. Staff noted that he was becoming confused and found it increasingly difficult to care for himself. On 6 October, an end of life pathway was begun, and the prison doctor thought the cancer might have spread to his brain. The man died the next day.

5. In light of the clinical reviewer's findings, we are satisfied that the clinical and end of life care the man received was equivalent to that he may have expected in the community, although care planning should have begun as soon as he was diagnosed with a terminal illness. We do not consider that the use of restraints when the man was taken to hospital near the end of his life was justified by an appropriately considered risk assessment.

THE INVESTIGATION PROCESS

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

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator obtained copies of the man's prison medical records and relevant aspects of his prison records. He interviewed staff from Garth and Preston with the clinical reviewer on 4 and 6 December and 24 January. The investigator gave the Governors of both prisons initial feedback on the investigation.

9. The investigator informed HM Coroner for Preston and West Lancashire of the investigation and the Coroner provided the cause of death. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's brother, his nominated next of kin, to explain the investigation. The man's brother had no specific issues he wished the investigation to consider.

11. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, liaison with his family, his location, whether compassionate release was considered; and security arrangements for escort and bedwatch.

12. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

13. The service also received a copy of the draft report. Their response to our recommendations and action plan is included at page 17 of this report.

HMP PRESTON

14. 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.

15. 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

16. The most recent inspection of HMP Preston was in April 2012. Inspectors noted that an appropriate range of health services was provided. Primary care services had improved and inpatient services were satisfactory, with an improved regime for prisoners living there.

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 recently published annual report for the year to March 2013, the IMB concluded that the management of the healthcare department at Preston appeared very effective.

Previous deaths at HMP Preston

18. The man was the sixth prisoner to die of natural causes at Preston since the beginning of 2011. We have previously made recommendations to Preston about risk assessments and the use of restraints for hospital escorts.

ISSUES

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

19. The man was serving a life sentence and moved to Garth in 2007. He had high blood pressure and peripheral vascular (blood vessel) disease, and had previously suffered transient ischaemic attacks (TIAs - small strokes causing minor and temporary symptoms). The man smoked heavily and refused advice to help him stop.

20. On 10 October 2012, a prison GP examined the man, who complained of a sore throat, toothache, earache and a headache. The man told the GP that he had been experiencing similar symptoms for around three or four months. The man's voice was hoarse and he found it painful to swallow. The GP noted that the man had swelling to his tonsils and, due to his symptoms, urgently referred him to an ear, nose and throat (ENT) specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

21. On 22 October, the man attended the ENT clinic at Royal Preston Hospital. A consultant head and neck specialist, noted that the man's tonsils were swollen and referred him for further examination on 26 November. This identified that the man had throat cancer.

22. The man attended an ENT outpatient clinic at Royal Preston Hospital on 11 December. The consultant told the man that he had cancer. A nurse saw the man when he returned to Garth that day. He noted that the man was aware of his diagnosis and would be returning to hospital for further examinations.

23. We are satisfied that the prison doctor referred the man quickly to a specialist when he first reported his symptoms and he was appropriately informed of his condition.

The man's medical treatment

24. On 12 December, the man discussed his illness with medical staff at Garth. The GP reviewed the man and prescribed medication for pain relief and high blood pressure.

25. On 8 January 2013, a consultant at Royal Preston hospital, saw the man and offered him curative radiotherapy or chemo-radiotherapy treatment. He told him that survival without treatment would likely be a matter of months, and that he would soon require palliative (symptom-relieving) care but the man declined any active treatment. There is no record that healthcare staff at the prison discussed the man's decision with him when he returned to the prison after this appointment.

26. Once it becomes evident that a serious medical condition will not be responsive to active treatment (or treatment is declined), it is appropriate that a palliative care plan is put in 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. There are various examples of end of life pathways.

27. On 18 January, the man told a prison officer that he was concerned that nobody had discussed palliative care with him. The officer contacted a nurse manager, and told her the man had said that he had refused treatment as he did not think it would benefit him, but he was frightened, in pain and had difficulty eating. The nurse manager and another nurse then discussed the man's future care and started a care plan.

28. On 21 January, a multi-disciplinary team discussed his illness and treatment options with the man. The team reviewed the man's pain relief and dietary requirements and frequent future reviews were planned.

29. The clinical reviewer concluded that the man was supported appropriately after the 18 January, but this support should have begun at the time of, or shortly after his diagnosis. We are satisfied that the man had multi-disciplinary support after 18 January, but there is little evidence of contact with healthcare staff immediately after his diagnosis and the follow-up appointment with the consultant. We are concerned that the man had to approach staff to ask for support and make the following recommendation:

The Head of Healthcare at HMP Garth should ensure that as soon as a prisoner is diagnosed with a terminal illness a care plan is begun to provide appropriate support and treatment.

30. After the meeting on 21 January, the man agreed to discuss treatment options with the ENT consultant. Accompanied by the nurse, the man attended a clinic with a doctor at Royal Preston Hospital on 29 January. The doctor told the man that a scan during his first appointment had shown a lung abnormality, which would require further examination.

31. The man had a further scan on 7 February, and on 26 February, the doctor told him that he had secondary, symptom-free, lung cancer. The man again declined chemotherapy treatment. He told the doctor that he had many years of his sentence left and did not want intensive treatment that did not guarantee a cure. The nurse manager told the investigator that staff had frequent discussions with the man about treatment options, but he was certain that he did not want any treatment.

32. The nurse was the central contact for the man's care needs. On 4 March, he referred the man to St Catherine's Hospice, local specialists in palliative and end of life care, for symptom management and psychological support. Specialists reviewed the man on 15 March. They noted that the man was fully aware of his illness and recommended adjustments to his medication. Staff from the hospice had frequent input into discussions about the man's care

and treatment, particularly in relation to pain relief, during the course of his illness.

33. The man experienced ongoing head and neck pain which was managed with painkillers including tramadol, pregabalin and morphine. Frequent medication reviews were held and adjustments were made to the man's anaelgesic regime when he reported being in pain. In April, healthcare staff began taking the man's medication to his cell as he was finding it difficult to collect it from the healthcare unit.

34. In June, the man's health continued to deteriorate. In addition to head pain, he started to experience vomiting and nausea and was prescribed anti-nausea medication. On 14 July, the man reported difficulty swallowing fluids and medication, and was given anaelgesia by syringe. The nurse told the man that he might now require 24 hour care at the Preston inpatient facility. An end of life care plan was begun. (An end of life plan is specific to the last few months and weeks of life. The emphasis is on minimising symptoms and pain, and should include pastoral and spiritual needs with continuing regular care planning meetings.) A doctor reviewed the man and prescribed Fentanyl (strong painkiller) patches to help with pain relief.

35. The man transferred to HMP Preston for end of life care on 17 July. The inpatient manager at Preston, met the man and updated his care plan. She noted that the man had refused cancer treatment and that this would be reviewed over time.

36. On 24 July, a prison GP discussed resuscitation options with the man. He recorded that the man understood his condition, along with the benefits and dangers of resuscitation. The man told the GP that he did not want to be resuscitated and agreed to a Do Not Attempt Resuscitation (DNAR) order, which was appropriately recorded. A DNAR 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.

37. The man completed a Preferred Priorities of Care document, setting out his end of life preferences, with the inpatient manager on 26 July. The man noted that he understood his condition and prognosis. He wanted to be cared for in a hospice close to his home at the end of his life.

38. The man experienced difficulties with his diet in prison as his ability to swallow decreased. Healthcare staff and kitchen staff discussed providing an appropriate diet. Initially there were some problems achieving this, but healthcare staff frequently reviewed the man's dietary requirements, with input from outside specialists. He received appropriate nutritional drinks and a soft diet. In August, the man agreed to have a radiologically inserted gastrostomy tube (RIG tube, a feeding tube) fitted at hospital to help him swallow. When he came back to the prison, the man told staff he was pain free.

39. The man's pain relief was reviewed often and adjustments to his anaelgesia were made as required, but he continued to experience nausea and vomiting.

He found it difficult to speak at times and staff gave him a notepad to help him communicate. On 18 September, the GP noted that it was becoming increasingly difficult to converse with the man because of the progression of his cancer.

40. On 4 October, the man's condition began to deteriorate. Staff noted that he was becoming confused and found it difficult to look after himself. In the early hours of 6 October, a nurse found the man crouched on the floor of his cell. He had not fallen, but was agitated, had been incontinent and was not fully conscious. A prison GP examined the man and concluded the cancer could have spread to his brain. He gave the man pain relief and, after a discussion with nurses, began an end of life pathway to cover the last days of life with the aim of ensuring the man's comfort.

41. Staff reviewed the man frequently as his condition deteriorated. A syringe driver (a small pump which administers pain relief under the skin) was available but not considered necessary and the care team gave the man painkilling injections as required.

42. On the morning of 7 October, a nurse noted that the man was no longer responsive to verbal communication, but appeared settled. The palliative care team reviewed his pain relief and decided to continue to give him painkilling injections as required as he was not distressed or in pain. Nurses assisted the man with his personal care and made him comfortable.

43. At 12.00pm, the inpatient manager checked the man and said that his condition had not changed from the morning. At 1.40pm, the inpatient manager returned to the man's cell to review his care needs and saw that he did not appear to be breathing. She was unable to find a pulse and recorded that the man was cold to touch. She called the GP who certified the man's death at 2.10pm.

44. The clinical reviewer found that the man's pain was reviewed regularly and his medication was adjusted as necessary. She considers that the end of life pathway was begun appropriately on 6 October, but notes that it was not formally recorded that it was discussed with the man. While this would have been best practice, we note that the man was gravely ill when this was implemented and that his end of life preferences had been discussed with him since July. The clinical reviewer concludes that the man received appropriate care and treatment at Preston at the end of his life, and we agree.

The man's location

45. When the man was first diagnosed with cancer, he lived on a residential wing at Garth. As his condition deteriorated, palliative specialists from St Catherine's Hospice suggested that he could be transferred to Preston, which has 24 hour and palliative care services. The man was initially reluctant to move to but accepted that it was necessary. At first he was unhappy about being at Preston, but shortly afterwards he was reported to be in good spirits and quickly settled in. He had a shared dormitory room but asked to move to

a single cell apparently because he did not want to share a television. Staff advised the man against moving to a single cell as the bed did not have a pressure-relieving mattress. However, the man signed a disclaimer and was allowed to move. The inpatient manager told the man he would need to be moved back to the dormitory, where there was more space for medical equipment and better staff access, when his condition deteriorated. The man remained in his single cell until 6 October, when he was moved to a dormitory room on his own after being placed on an end of life pathway. The door was kept unlocked from the outside to allow healthcare staff easier access at the end of his life.

46. The man stated that he would like to move to a hospice, and a number of possible locations were explored, but were found not to be suitable. The nurse manager told the investigator that the man then wanted to remain in prison after he found he could not go to his preferred hospice. After he returned from hospital in August he appeared to change his mind again and on 2 September he told staff he wanted to go to St Catherine's Hospice. An application for compassionate release to St Catherine's was refused and the man remained in prison until his death. The nurse manager and the inpatient manager told us that the man was probably too unwell to move to a hospice at the end of his life because his condition deteriorated rapidly.

47. Although the man was unable to transfer to a hospice, staff had frequent discussions with him about his location and the reasons for remaining at Preston. We are satisfied that Preston was a suitable location with appropriate facilities to provide end of life care for the man.

Restraints, security and escorts

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

49. 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 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 regarding 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.

50. The man went to hospital ten times after he was diagnosed with a terminal illness. On 6 August, the man was admitted to Royal Preston Hospital as an inpatient for a feeding tube to be fitted. Staff from Preston completed the risk assessment. The medical section gave no medical objections to the use of restraints, but recommended 'standard' cuffing procedures rather than the usual double-handcuffing for a category B prisoner. It was noted that the man had the ability to escape. Security staff at Preston assessed all of the man's risks as medium, including his risk of escape and risk to the public. They recommended the use of restraints and a two-officer escort as the man was a category B prisoner.

51. However the Head of Security at Preston, instructed that prison staff should use 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). She noted that the man was wheelchair bound with very limited mobility. She directed that the man should be restrained until his operation, when the duty governor would review the security arrangements. Staff from Garth escorted the man to hospital.

52. The man remained in hospital until 20 August. He was restrained by an escort chain, which was removed during his operation and replaced afterwards. A Duty Governor directed that single handcuffs should be used when he returned to prison.

53. When the man went to hospital on 6 August, he had advanced symptoms of cancer. A medical report by a doctor on 9 August stated that it was extremely unlikely that the man could be considered a danger to anyone else because of his physical condition. The inpatient manager told us that the man was only mobile around his bed space and it was highly unlikely that he would be able to escape.

54. In light of the man's poor health and lack of mobility, we do not consider the risk he presented warranted the use of restraints in addition to a two-officer escort. The medical assessment before his admission did not refer to the man's condition or the reason for his admission. The head of security acknowledged the man's lack of mobility, but directed the use of an escort chain and as a result he was restrained for the next 14 days.

55. The clinical reviewer shares our concerns about the use of restraints. Healthcare staff we interviewed were unaware of the guidance in the High Court judgement of 2007 and did not know they could question the use of restraints on terminally ill prisoners. The clinical reviewer recommends that the Head of Healthcare at Preston informs the nursing team that terminally ill prisoners should only have restraints applied on escort if there are justifiable reasons documented.

56. We have made previous recommendations to Preston about the use of restraints. We consider there is a need for all those involved in making decisions to ensure that a prisoner's health and mobility are fully taken into account in risk assessments for hospital escorts and that staff follow the guidance in the High Court judgment, which has recently been repeated in a

National Offender Management Service (NOMS) senior leaders' bulletin. We make the following recommendation:

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

Liaison with the man's family

57. The man had little contact with his family during his illness. On 8 January, he told the doctor not to contact his family about his diagnosis and the doctor informed Garth of the man's decision.

58. On 3 July, the man told a palliative care specialist from St Catherine's Hospice that he had contacted those who needed to know about his illness and said there was no need to communicate with anyone else. The palliative care specialist informed Garth of this discussion.

59. When the man transferred to Preston in July, the inpatient manager said that the man was content for her to contact his brother, his nominated next of kin, but said he did not require any support from his family. The inpatient manager discussed the man's condition with his brother. The inpatient manager said that the man's brother was aware of his illness and prognosis but said that the man did not want him to visit.

60. On 9 August, an operational manager at Garth, was assigned as the man's family liaison officer. He spoke to the man's brother and helped arrange for him to visit the man in hospital.

61. The chaplain at HMP Preston, contacted the man's brother on 6 October when it was apparent he was dying. He understood the man had little time left to live but decided not to visit, in line with the man's wishes. The chaplain and the man's brother agreed that the prison would keep him updated by telephone. On 7 October, the Deputy Governor at Garth, telephoned the man's brother to inform him of his death. The family liaison officer continued contact with the man's family after his death. In line with national guidance, Garth contributed to the funeral costs.

62. We are satisfied the man's family was kept informed when his condition deteriorated and that contact was appropriate and in line with the man's wishes.

Compassionate release

63. Prisoners can be considered for release on compassionate grounds for medical reasons. In order to be released on these grounds, a prisoner must have been diagnosed with a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

64. On 6 July, the man's offender supervisor at Garth, began an application for compassionate release on his behalf. At the time the man moved to Preston he was given a prognosis of less than 12 months to live but doctors were unable to give a clearer prognosis. On 9 August, a prison GP, stated that the man's prognosis had previously been 6 months but he had deteriorated and was unlikely to survive very long. However, a doctor reviewed the man on 6 September and gave an updated prognosis of around 8 months.

65. The staff we interviewed said that the man often changed his mind about his preferred location should be released. His preferred hospice in his home area was not considered suitable because of risk factors. St Catherine's Hospice in Preston agreed to consider a referral when the man was in the last days of his life.

66. This application was submitted to the Public Protection Casework Section on 12 September and refused because there was no clear prognosis and no clear release plan or address at that stage. The level of risk was also regarded as too high. Staff at Garth and Preston continued to review the man's condition after the initial application was turned down. However, no further application was made before he died. In September his prognosis was 8 months. At the beginning of October the man's condition deteriorated very quickly and the staff told us that the man was too unwell to leave Preston at the end of his life.

67. We are satisfied that Garth submitted a timely application for compassionate release. When it was turned down, both prisons continued to review the man's condition and prognosis. Sadly, due to the rapid decline in the man's condition at the end of his life, the application could not be reconsidered before he died.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Garth should ensure that as soon as a prisoner is diagnosed with a terminal illness, a care plan is begun to provide appropriate support and treatment.

2. The Governor and the Head of Healthcare should ensure 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	Progress (to be updated after 6 months)
1	The Head of Healthcare at HMP Garth should ensure that as soon as a prisoner is diagnosed with a terminal illness, a care plan is begun to provide appropriate support and treatment.	Accepted	The Lancashire Care Foundation Trust Palliative Care and Cancer Care Protocol will be distributed to all clinical staff via individual e-mails and discussed at a team meeting during April 2014. This will include a flow chart to inform staff of the procedure to follow when a prisoner is diagnosed with a terminal illness including the formulation of a care plan. The Lead nurse will attend training, awareness sessions and meetings provided by the local Hospice and Trust and will feedback any new learning in team meetings.	June 2014 Lancashire Care Foundation Trust Palliative Care and Cancer Care Protocol	
2	The Governor and the Head of Healthcare should ensure 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	Further to NOMS guidance issued to Governors in 2008 following the Graham judgement, subsequent guidance was issued to all Governors and Directors on the use of restraints, most recently in January 2014. The Governor of HMP Preston has disseminated this guidance in a notice to all staff, and has reinforced it in oral briefings to custodial managers and healthcare staff. The risk assessment procedure at HMP Preston has been reviewed. In line with the national guidance, healthcare staff now provide more detailed information about mobility and other relevant factors about the individual	Completed Governor	

			prisoner to inform the risk assessment before he is taken to hospital. The risk assessment documentation also states explicitly that escorting staff must contact the prison if there is any deterioration in the prisoner's health while they are at the hospital. These requirements have been repeated to relevant staff and managers by the Governor, who is confident that decisions taken now are much better informed, reflecting each prisoner's health and mobility. NOMS is absolutely committed to treating prisoners with dignity whilst discharging our responsibilities to keep them in custody and to ensure the safety of hospital staff, other patients and the wider public.		