PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in February 2011 at HMP Elmley

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Elmley. He died in February 2011 at a hospice of end stage liver disease due to Hepatitis C. He was 47 years old. I offer my condolences to his family and all those affected by his death.

A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. Elmley co-operated fully with the investigation. I apologise that the report has been delayed.

The man's illness was diagnosed appropriately. His condition had been caused through an excessive intake of alcohol over several years. Treatment options were limited and he was considered unsuitable for a liver transplant because he had been unable to demonstrate the ability to abstain from alcohol when not in prison.

The possibility of compassionate release had first been considered in June 2009, but the application was refused as the man's death was not believed to be imminent. When his health deteriorated in February 2011, the change was so rapid that there was insufficient time for a further application for compassionate release to be progressed. However, he was granted release on temporary licence and he moved to a hospice for the final days of his life.

The investigation has identified some areas for improvement in relation to recording hospital letters and prescribing decisions on medical records, the appointment of a family liaison officer when prisoners are first diagnosed with a terminal illness and the desirability of using a formal end of life pathway. However, overall I am satisfied that the man received a good standard of care at Elmley.

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 **November 2012**

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SUMMARY

1. The man arrived at HMP Elmley on 23 October 2007 after he breached his licence conditions while on release on temporary licence (ROTL) from an open prison. No significant medical issues were noted during his first reception health screen except a history of drug and alcohol abuse.

2. The man first began to show symptoms of a decline in health in January 2009. These included swelling to his legs, which was initially diagnosed as deep vein thrombosis (DVT). Further tests showed that he was suffering from liver disease and Hepatitis C. A referral was made to a hospital to determine the appropriate treatment for his condition and he moved to the inpatient unit at Elmley so he could receive 24 hour care.

3. Because the man had been unable to show that he could abstain from drugs and alcohol in the community, he was not considered suitable for a liver transplant. Instead his condition was controlled using various pain relief and diuretic medications. He attended hospital regularly for further treatment.

4. The man received support from community palliative care nurses in addition to that provided by healthcare staff at Elmley. The clinical reviewer found that the overall management of his care needs was of a high standard and equivalent, if not better, than would be expected in the community. When his condition deteriorated, he was moved to a hospice and was released on temporary licence. He died in February 2011.

THE INVESTIGATION PROCESS

5. The investigator first visited Elmley on 16 February 2011 and examined the man's prison records. She visited the in patient unit where the man lived during his time at the prison.

6. During the visit, the investigator met a member of the Independent Monitoring Board (IMB) who had no concerns about the man's treatment. Notices to staff and prisoners were displayed at the prison, inviting anyone with information about the death to come forward. There was no response to the notices.

7. A clinical review of the man's healthcare was commissioned by the local Primary Care Trust (PCT).

8. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and to invite them to ask any questions or raise any issues for consideration. The family raised the following concerns:

    - That the rapid deterioration in the man's condition might have been caused by the prescribed medication being unsuitable for someone with a liver condition.
    - That there were occasions when he had received his medications late or not at all.
    - That restraints were used when he was receiving medical treatment despite his poor health and low categorisation.
    - That they were not told on the occasions when he was admitted to hospital.

9. The family also questioned why the man was still in custody when he had served more than his original tariff. Decisions about the release of life sentenced prisoners are a matter for the independent Parole Board and are not within the remit of this office.

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

11. We apologise for the delay in issuing this report and for any additional distress this may have caused. The delay was caused through workload pressures and staff absences.

HMP ELMLEY

12. HMP Elmley opened in 1992 and is a local prison serving Kent and many of the courts in the county. The prison holds up to 1252 remand and sentenced prisoners. The prison consists of six residential houseblocks, a healthcare unit and segregation unit.

Her Majesty's Inspectorate of Prisons

13. HM Inspectorate of Prisons conducted its most recent inspection of Elmley in March 2012. Although inspectors found that prisoners were relatively negative about access to and the quality of healthcare, inspectors were generally positive about the provision and commented:

> "Health care management arrangements were robust and the health care centre provided a good range of facilities. Primary care services were satisfactory, with all prisoners receiving a comprehensive initial screening. GP clinics took place regularly and the high rate of non-attendance had reduced significantly. There was a good range of nurse and specialist led clinics, and attendance at outside hospital appointments were well managed. Inspectors also noted that palliative care and an end-of- life pathway had been developed and used successfully with the cooperation of local services".

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Elmley concluded that the prison had maintained a good standard in most areas of care. The IMB noted that the inpatient unit was always very busy with the accommodation full most of the time and that the staff in the unit were very helpful.

Previous deaths in custody at Elmley

15. In the five years before the man's death, there were two other deaths through natural causes at Elmley. None of the recommendations made following those investigations are repeated here.

ISSUES

The diagnosis of the man's terminal illness

16. The man was convicted of murder in 1993 and sentenced to life imprisonment with a minimum period to serve of 12 years before he could be considered for release. During his sentence he spent time in various prisons, two as a category D prisoner in open conditions. On 23 October 2007, he returned to closed conditions at HMP Elmley because he had breached his licence conditions during a period of release on temporary licence from an open prison. During his first reception health screen, he said that he was a smoker and had a family history of heart problems. He said he suffered from chronic headaches and had been prescribed migraine medication. No other concerns regarding his physical health were noted. He reported having previously used heroin, codeine and Subutex (an opioid used to wean people off addiction to stronger opioids such as heroin). He also reported a long history of alcohol use. He continued to use illicit drugs in prison leading to him being placed on a detoxification programme, followed by a maintenance programme of 30ml of methadone until August 2009.

17. On 29 January 2009, the man was seen by a prison doctor because he had a swollen left leg. The doctor was concerned that he might have deep vein thrombosis (DVT) and sent him to hospital for further investigation. While at the hospital he was given an injection of fragmin[1]. He returned to Elmley the same day. The discharge summary said an appointment had been arranged for him to have a CT scan[2] of his leg on 6 February and the fragmin injections should continue daily until that time.

18. The man was examined by another prison doctor on 3 February. His abdomen was distended and firm to the touch. His legs were still swollen and his liver area was enlarged.

19. The man continued to suffer from a distended abdomen and, on 6 February, he was examined by a third prison doctor. The doctor thought that he might be haemorrhaging internally due to anti-coagulant medication and referred him to a consultant gastroenterologist[3] at the hospital. Tests at hospital showed he had chronic liver failure. He returned to Elmley on 9 February, and moved to the in-patient unit two days later.

20. On 17 February, a prison doctor noted in the man's records that he was still experiencing discomfort and tenderness in his abdomen. The doctor referred him back to hospital for further tests. The results were received on 19 February, and showed that he was suffering from chronic liver disease, secondary to cirrhosis.

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[1] Fragmin is an anticoagulant which is used to prevent blood clots such as deep vein thrombosis.

[2] A CT scan is a computerised tomography scan. It uses X-rays and computer graphics to create detailed images of the inside of the body.

[3] A gastroenterologist specialises in the treatment of conditions affecting the liver, intestine and pancreas.

21. On 26 February, the man was taken back to hospital because his abdominal distension had not improved. He was also suffering from swelling in his groin. The results of a CT scan showed that he was suffering from decompensated liver disease[4] secondary to Hepatitis C infection. In addition, he had cirrhosis and grade 1 oesophageal varices[5] and portal hypertension[6]. The gastroenterologist suspected that his conditions had been caused by his previous use of drugs and alcohol. He returned to Elmley on 11 March.

22. The clinical reviewer was satisfied with the timeliness of the man's diagnosis.

Informing the man about his condition and treatment

23. The man was seen by a prison doctor on 19 February 2009 for an explanation of the results of the liver function test. He was told that he was suffering from chronic liver disease, secondary to cirrhosis. After meeting with the doctor, he told healthcare staff that he felt much better because some of his questions about his condition had been answered.

24. The doctor spoke to the man again about his condition and prognosis on 26 March. He explained to him that he could deteriorate quite quickly at any time and suggested that if he wanted to see his family he should make arrangements to do so while his health remained stable. He was provided with information leaflets about liver disease and Hepatitis C.

25. The man's medical records show that he was regularly given the opportunity to discuss his diagnosis with healthcare staff and spent time talking about the progression of his condition and how he was feeling.

26. The clinical reviewer has commented that there are multiple episodes in the man's medical record where his condition was discussed with him by prison doctors and the nursing and palliative care team from the hospice. He notes that he received one to one support from a nurse in the in-patient unit to enable him to discuss his thoughts and feelings.

The man's medical appointments and treatment following diagnosis

27. Following the man's diagnosis, he had a number of acute admissions to hospital which were primarily for the drainage of fluid build up in his abdomen. The clinical reviewer found that the discharge summaries from the hospital were concise and informative. He has commented that prison healthcare staff checked him almost daily, particularly when his condition deteriorated. The checks included the recording of his vital functions of blood pressure, pulse and temperature.

28. The man was prescribed two diuretic medicines to deal with his symptom of fluid retention. These were originally prescribed by one of Elmley's doctors following a consultation with him on 19 February 2009. The prescription was

[4] Decompensated liver disease means that the liver is damaged and is not functioning.
[5] Abnormally enlarged veins of the oesophagus (the food pipe).
[6] High blood pressure in the veins supplying the bowels and stomach.

for furosemide at 40mg (milligrams) twice per day and spironolactone at 100 mg twice per day.

29. In July 2010, the man was seen at the liver clinic at hospital. He was found to have a reduced sodium level and a letter was sent to the prison suggesting that the dose of both drugs should be halved to furosemide at 40 mg per day and spironolactone at 100 mg per day. However, he continued to be prescribed both medications at the original dose. There is no entry in his medical record referring to the hospital letter or why the decision was made to continue at the existing dose.

30. The man's family questioned whether the rapid deterioration in his health was caused by his prescribed diuretics (furosemide.and spironolactone). The over-prescribing of diuretics can accelerate kidney failure in patients with chronic liver disease, but the clinical reviewer's view is that this was not the case with the man as he was already in end stage hepatic failure. Nevertheless, there should have been a reference to the hospital letter and the decision about the prescription in his medical record.

    The Head of Healthcare should ensure that letters received from hospital consultants are reviewed by a prison doctor and relevant information noted in the prisoner's electronic medical record.

31. The man had a number of medical appointments to consider his suitability for a liver transplant. A referral about this was sent by the hospital to another hospital. The original cause of his liver damage had been his long term history of drug and alcohol abuse. This history, along with his prevailing attitude to drugs and alcohol was explored by an alcohol and substance misuse clinical nurse specialist at the hospital. A similar assessment was carried out by a prison forensic psychiatrist. The matter was discussed in due course by a multi-disciplinary team which concluded that the man would need to demonstrate significant evidence of abstinence and avoidance of drug and alcohol in a community setting before he would be considered for a liver transplant. This was explained to him.

The man's pain relief and medication

32. The man's pain relief was managed using strong analgesics (pain killers) such as oxycodone hydrochloride (an opioid analgesic). The clinical reviewer has pointed out that prescribing appropriate pain relief for him was a complex issue as he had previously had an opiate (heroin) dependency. The reviewer goes on to explain that the prescribing of analgesics in the man's case was continually supervised by the palliative care team (Macmillan nurses) from the local hospice. Adjustments to prescribed medication were made as appropriate and in collaboration with staff from Elmley's integrated drug treatment scheme (IDTS). The man was also prescribed fentanyl patches[7] and morphine sulphate. The clinical reviewer concludes that Elmley was able to achieve its aim of providing adequate pain control for the man.

[7] Fentanyl is opioid painkiller. The fentanyl patch is worn on the body and allows continuous absorbtion of the drug into the bloodstream.

33. The man's family questioned whether he always received his prescribed medication. We have found no evidence of any omissions.

34. In addition to provision of appropriate pain relief, the man was also supplied with adequate comfort aids. This included a modified bed that could be adjusted as needed, along with an appropriate air mattress and cushion for pressure relief. The air mattress was later replaced with a memory foam mattress when the former mattress became too uncomfortable. The man was also provided with a comfortable chair and foot stool and his toilet seat was raised.

The man's location

35. Following his diagnosis, the man was moved on 11 February 2009 from the wing to the prison's healthcare in-patient unit. Apart from the times when he was at outside hospital, he stayed in the in-patient unit until moving to the hospice just before his death. His cell door in the in-patient unit was left open throughout the day which allowed healthcare staff easy access to his cell and assisted his care.

36. Following deterioration in his condition on 24 January 2011, the man was sent to hospital. He returned to Elmley the next day following discussion between hospital staff and the prison healthcare staff who considered that they were able to provide the level of care that he needed.

37. A doctor at Elmley remained concerned about the prison's ability to continue to care for the man and, on 3 February he assessed him, assisted by a Macmillan nurse. They concluded that the man should move to the hospice and he was transferred there the following day.

38. The clinical reviewer considers that the decision that the man should initially live in the in-patient unit at Elmley was appropriate. He commented that Elmley was equipped to care for terminally ill prisoners and had the services of a specialist end of life nurse. He has questioned whether the man could have been moved to a hospice sooner. However, he notes that the management of a severely deteriorating patient is complex and all parties would need to agree that the patient is close to death before a move to a hospice could be considered.

39. We are satisfied that the man was appropriately located in the prison in-patient unit and healthcare staff liaised with the hospice and arranged a place there when it became clear that the man was too ill to remain in prison.

Palliative care

40. Following a diagnosis of chronic liver failure a care plan was created for the man which started when he returned to Elmley from hospital on 11 February 2009. The care plan outlined his needs and how they would be met. In particular it was recorded that his abdominal girth should be measured on

weekly basis by a designated nurse and weighed twice a week to monitor his ascites[8]. Separate care plans were created to assist the man with his daily routine and to monitor his mental health.

41. The man was referred to the community palliative care team at the hospice on 8 April 2009 by the in patient manager. The referral said that he needed pain and symptom control, emotional support and should be assessed for palliative care.

42. On 15 April, the man was visited at Elmley by the MacMillan nurse and the prison's palliative care nurse. Various items of equipment were identified to assist the man with his daily life, such as a raised toilet seat and an overlay mattress. Following a discussion between the MacMillan nurse and a doctor, his pain relief was amended. He was encouraged to tell healthcare staff if he experienced any pain. He was described as having good insight into his condition and understood that the palliative nurses were concerned with improving his comfort.

43. The man was seen regularly by the community palliative care team who made recommendations to make his daily life more comfortable. This included an electric bed and an air mattress. His diet was also reviewed and he was encouraged to eat foods with a high fat content.

44. Having reviewed a full set of the man's medical records we are satisfied that his care was appropriately co-ordinated using three care plans. However, there is no evidence that staff used a formal palliative care and end-of- life pathway, although these have been developed at Elmley. The benefits of an end-of-life pathway include that they help carers to plan the delivery of care and help patients in making choices about how they are cared for towards the end of their lives. While many of the matters covered by an end-of-life pathway were included in his care plans and we make no criticism of his care, best practice would have been to use a formal documented pathway to help ensure that no matters were overlooked.

    The Head of Healthcare should ensure that a formal end-of-life pathway is implemented when a prisoner nears the end of life.

Compassionate release

45. Prisoners who are diagnosed with a terminal illness can be considered for early release on compassionate grounds. Prison Service Order 6000 (Parole release and recall) explains that the principles underlying the approach for early release on compassionate grounds are:

    - The release of the prisoner will not put the safety of the public at risk.
    - A decision to approve release would not normally be made on the basis of facts which the sentencing or appeal court was aware.
    - There is some specific purpose to be served by early release.

[8] Ascites is a build up of fluid in the abdominal cavity.

46. Early release might be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. The decision to release a prisoner on compassionate grounds is made by the Secretary of State taking into account information provided by Prison Service staff and medical opinions. There are no set time limits in considering whether the prisoner is likely to die "soon", but a life expectancy of three months is considered an appropriate period and a clear medical opinion on life expectancy is required. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family.

47. On 12 March 2009, a doctor completed a medical report form as part of the compassionate release process. The report said that the man was suffering from end stage liver cirrhosis. His prognosis was poor with an estimated survival rate of less than twelve months.

48. A meeting was held between the man and the Lifer Clerk at Elmley on 26 May 2009 about the possibility of compassionate release. A prison nurse and the man's offender manager in the community were also present. The nurse wrote a summary of his condition for his offender manager, which was faxed to her on 29 May. The summary stated that the man had been diagnosed with end stage liver disease while in hospital and this had been confirmed in the doctor's medical report. The nurse did not think that being in custody would reduce the man's life expectancy. He was waiting to be reviewed by a consultant from the hospice and it was likely that he would be moved to the hospice when his condition deteriorated.

49. The man's offender manager wrote to the Offender Management Unit at Elmley on 9 June and said that in her opinion he did not meet the criteria for early release on compassionate grounds at that time and his application for early release on compassionate grounds was not progressed further at that stage. A note was made in his Lifer Contact Record that he was told of the decision.

50. The man's records contain no mention of any further consideration of compassionate release until the very end stages of his life. An entry dated 3 February 2011 referred to advice from a palliative care nurse that he might have only 72 hours left to live. One of the Ombudsman's investigators spoke to an offender supervisor at Elmley, who said that she had been in frequent contact with Elmley's healthcare manager and before 3 February there was no clear information that the man might be close to death. At that stage she told a prison manager about the developments and she asked for the compassionate release process to be restarted.

51. An application for early release on compassionate grounds has to be approved by the Public Protection Casework Section (PPCS), a casework unit within the National Offender Management Service (NOMS). Elmley contacted PPCS who advised that they needed further information about the man's mobility and chances of recovery and indicated that there might be too little time remaining

for the processes to be completed. Elmley also contacted the man's community based offender manager, who also requested further information to enable her to write a report on suitability for early release. Sadly, the man's condition continued to deteriorate very quickly and he died at the hospice before the processes could be progressed.

52. While it had not been possible to complete the process for early release on compassionate grounds, Elmley arranged for the man to be released on temporary licence (ROTL) when he moved to the hospice on 4 February 2011. This meant that he was able to receive unrestricted visits from his family before he died.

Liaison with the man's family

53. The man's nominated next of kin was one of his two brothers. Following his diagnosis he was encouraged by healthcare staff to contact his brother and other family members to tell them about his condition.

54. On 3 February 2011, the day before his scheduled move to the hospice, the man attempted to telephone his brother by telephone. These efforts were unsuccessful so the prison's family liaison officer intervened and was able contact the brother later that day. The family liaison officer explained the deterioration in the man's condition and that he was likely to die soon. He offered the brother the opportunity to come to Elmley and to pay any travel costs. He also contacted the man's other brother with the same information.

55. When the man moved to the hospice on 4 February, the family liaison officer contacted the brother to let him know. Elmley paid for a taxi to take him and his family to the hospice.

56. The family liaison officer met the man's brother, uncle and cousin at the hospice on 6 February and discussed with them their concerns about his condition. Following the man's death the hospice contacted his family to let them know. The family liaison officer was told about the death the following morning and immediately telephoned the man's brother to offer his condolences. He explained that the prison would meet the funeral expenses. He kept in regular contact with the family and attended the funeral.

57. The man's family spoke very positively about the help and support they had received from the family liaison officer. However, they have asked why they were not told by Elmley about other occasions when he was admitted to hospital. Unless a prisoner is seriously ill or so ill they cannot make contact themselves, or they ask prison staff to do so, there is no general expectation that prison staff should contact a prisoner's family each time they are admitted to hospital. Staff at Elmley had encouraged him to inform his family about his illness, and that would include times when he was scheduled to go to hospital for tests and treatment. It is unclear the extent to which the man informed his family about the progress of his illness and his treatment.

58. However, when a prisoner is terminally ill, it is good practice to appoint a family liaison officer at an early stage. They can have discussions with the family about how they would like to be contacted and with the prisoner's consent make arrangements to be kept in touch. In this case the family liaison officer was not appointed until a late stage.

The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to discuss and take forward contact with the prisoner's family in line with the prisoner's wishes.

Restraints and security

59. Before the man was taken to hospital on 29 January 2009 the security department carried out an initial risk assessment based on his offence and security categorisation. The risk assessment noted that he was a category D prisoner. He was assessed as being a low risk to the public and to hospital staff. There were no concerns that he would attempt to escape from custody. He was accompanied by a prison officer when he was taken to hospital, but no restraints (handcuffs) were used. The same arrangements were made on the further occasions that he went to hospital.

60. The man's family were under the impression that restraints were used when he was receiving treatment in hospital. Having reviewed the prison records we have been unable to find any written record that he was restrained during his treatment from January 2009, but we cannot discount that it is possible that he might have been restrained on earlier occasions.

CONCLUSION

61. The man was diagnosed in February 2009 with liver disease secondary to Hepatitis C infection. His conditions had arisen through his misuse of drugs and alcohol in the community. He was referred in a timely manner to hospital when he began to develop symptoms of excessive fluid retention. A referral to another hospital was made to consider his suitability for a liver transplant. However, he was deemed unsuitable for a transplant as the criteria for such a procedure include the need for the patient to demonstrate total abstinence from drugs and alcohol in a community setting.

62. The clinical reviewer notes that Elmley did not act upon hospital advice in July 2009 that the doses of the man's diuretic medication be reduced but he does not believe that this omission had a direct bearing on the progress of the man's condition. With regard to the overall management of his condition, the clinical reviewer found that his care was of a high professional standard involving multiple agencies and was of an equivalent, if not higher, standard than he might have expected in the community.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Head of Healthcare should ensure that letters received from hospital consultants are reviewed by a prison doctor and a note made in the prisoner's medical record.

   Recommendation accepted
   All letters received from hospital consultants are reviewed and signed by the prison doctor then scanned onto the prisoner's electronic medical record. Action is complete and in place.

2. The Head of Healthcare should ensure that a formal end-of-life pathway is implemented when a prisoner nears the end of life.

   Recommendation accepted
   The End of Life Strategy has been adapted in conjunction with the local Hospice and is in place. Action is complete and in place.

   The Liverpool Care Pathway training programme is being implemented for all prison healthcare staff. Target for completion is November 2012.

3. The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to discuss and take forward contact with the prisoner's family in line with the prisoner's wishes.

   Recommendation accepted
   The Head of Healthcare will inform the Governor if a terminal diagnosis is made. An FLO will be appointed and make and maintain contact with the family according to the patient's wishes. Action is complete and in place.