

**Investigation into the death of a man in May 2011
at St James's Hospital, whilst in the custody
of HMP Wakefield**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2011

This is the report into the death of a man in May 2011, at St James' Hospital in Leeds, whilst in the custody of HMP Wakefield. The post mortem report showed that he died of cancer of the pancreas and prostate. I offer my condolences to those affected by his death.

The investigation was carried out by one of my senior investigators. I would like to thank the Governor of HMP Wakefield and her staff for their co-operation throughout the course of the investigation.

I am grateful to Wakefield Primary Care Trust for appointing the clinical reviewer to conduct a review into the man's clinical care. The clinical review plays an essential part in my report and shows that the man received an equitable level of care compared to that which he could have expected in the community.

The man was serving a life sentence for serious offences. He had been at HMP Wakefield since August 2000. In 2009, he was diagnosed with prostate cancer. The man was consulted about his treatment options and initially asked for surgery to remove the cancerous areas. When hospital staff advised that surgery was no longer an option, he began hormone therapy and was due to begin a course of chemo-radiotherapy.

Shortly before beginning further treatment, the man developed jaundice and was diagnosed with inoperable pancreatic cancer. He was admitted to hospital, where he remained until his death. Both hospital and prison healthcare staff continued to involve him in decisions regarding his care. It was the man who decided that he wanted "life to take its course" and elected not to be resuscitated if he stopped breathing.

I am pleased to find that Wakefield healthcare staff provided a good level of care to the man. I make no recommendations as a result of this investigation.

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.

Thea Walton
Acting Deputy Ombudsman

December 2011

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SUMMARY

1. The man was serving a life sentence for serious offences. He had been at HMP Wakefield since August 2000. In 2009, he was diagnosed with prostate cancer. As a result of his prostate being enlarged, he suffered from urinary incontinence and had a catheter (a thin tube which is passed through the urethra into the bladder) inserted. The catheter frequently became blocked and he suffered many urinary tract infections, which were treated with antibiotics.
2. The man initially requested surgery to treat the cancer. However, the hospital consultant and healthcare staff advised him that surgery was not a suitable option and suggested he undergo hormone therapy and a course of chemo-radiotherapy treatment instead. (Hormone therapy is a common treatment for prostate cancer. It works by stopping the body from producing the hormone testosterone. This can help to shrink the tumour. Chemo-radiotherapy is the combination of radiotherapy and chemotherapy.) He was reluctant to start any treatment other than surgery, but in November 2010 began the hormone therapy and was intending to start a course of radiotherapy treatment.
3. The man developed jaundice (the yellowing of the skin, caused by a build up of a naturally occurring bodily waste product) just before he was due to start the course of radiotherapy. Tests were conducted to try and establish the cause of jaundice and it was suspected that he also had pancreatic cancer. The man was admitted to hospital on 8 April 2011, and subsequent blood tests showed he had a very abnormal liver function and that his kidney function was poor. A scan confirmed that he had inoperable pancreatic cancer.
4. After being diagnosed with pancreatic cancer, the man stated that he wanted to "let cancer take its course" and that he would like to return to his cell on the prison wing. Staff persuaded him to stay in hospital over the weekend so that he could receive adequate clinical care. He told staff that he did not want any next of kin notified of his condition until after his death and provided the contact details of his step-sister. His condition began to deteriorate and he was given antibiotics via an intravenous line, refusing any other treatment. He died in hospital

THE INVESTIGATION PROCESS

5. My investigator opened the investigation at HMP Wakefield on 18 May 2011 and took copies of all relevant documentation relating to the man. She met with prison managers and issued notices to staff and prisoners inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No-one came forward in response to the notices.
6. Wakefield Primary Care Trust (PCT) appointed the clinical reviewer to undertake a review of the clinical care the man received at Wakefield. The clinical reviewer received copies of relevant medical documentation, upon which he based his findings.
7. My investigator contacted HM Coroner for West Yorkshire (Eastern District) to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
8. The man was estranged from his family and had not been in touch with them for some years. Efforts to trace them after his death were unsuccessful as the address that the man provided for his step-sister before his death proved to be incorrect. As a result, my office has not had any contact with the man's family during this investigation.
9. The investigation assesses the following aspects of the man's care and treatment:
 - Whether his diagnosis was made in a timely fashion?
 - Whether he was told about his condition and the treatment which followed?
 - Whether he was treated properly and attended hospital appointments as necessary?
 - Whether the liaison with his family was appropriate?
 - Whether he was accommodated in the most appropriate part of the prison?
 - Whether consideration was given to compassionate release from prison?
 - Whether appropriate palliative care was provided?

HMP WAKEFIELD

10. HMP Wakefield is a high security prison for men. The operational capacity of the prison is 751 men, who are primarily serving sentences of over five years for sexual offences. There are four main residential units, with each wing holding around 185 prisoners in single cells.
11. Health services are commissioned by Wakefield District Primary Care Trust and provided by the private company, Spectrum. There is a new primary care centre at the prison, consisting of the prison doctor's consulting room and a treatment hatch (where prisoners' collect their medication). The main healthcare centre has consulting rooms for the dentist and optician, as well as a 19 bed inpatient unit.

HM Chief Inspector of Prisons (HMCIP)

12. HM Chief Inspector of Prisons last inspected Wakefield in December 2008. The report noted that many older prisoners and those with disabilities complained about a lack of support and felt they were not consulted about their individual needs and care. It was also noted, however, that there was a committed member of staff who worked as disability liaison officer and coordinator for older prisoners. The report also noted that prisoners had to wait too long to see the prison doctor and too many outside hospital appointments were cancelled with little monitoring of the reasons. None of the issues raised by HMCIP arose in this investigation.

Independent Monitoring Board (IMB)

13. Each prison in England and Wales is monitored by a board of unpaid members of the local community appointed by the Secretary of State for Justice. One of the roles of the Board is to ensure that prisoners are held in safe and decent conditions. The Wakefield IMB report for 2009-10 highlighted concerns regarding the suitability of accommodation and activities for older prisoners and those with disabilities. They reported that the healthcare team provided a comprehensive service, but noted their concern at a shortage of healthcare staff as a number were suspended following a security incident.
14. The man was the tenth prisoner to die from natural causes at Wakefield in the last two years. However, there appear to be no similarities between the previous deaths and that of the man.

ISSUES

The diagnosis of the man's illness

15. On 17 July 2009, the man, who had diabetes, had a routine blood test, the results of which indicated that he might have problems with his prostate. (The test showed he had a raised Prostate-Specific Antigen – PSA – level. PSA is the protein produced by the prostate gland. Small amounts of PSA are present in healthy men, but elevated levels can indicate prostate cancer). The clinical reviewer notes that a raised PSA level is a poor predictor of prostate cancer, but needs monitoring nevertheless.
16. As the man had been on a high level of diabetes medication, metformin, just before the test was taken, it was to be repeated once the metformin dose had been reduced and his body had adjusted to it. The man had another blood test in August that also showed the PSA level was raised. Healthcare staff considered referring the man to the “one stop prostate clinic” at the local hospital. However, they decided that he should undergo a urine test first to rule out a urinary tract infection. When the results of this test were negative, he was referred to the prostate clinic on 1 September.
17. The man's protein level was even higher in October and he was also beginning to suffer with difficulty urinating. He underwent a urological review in hospital on 12 October and was diagnosed as having benign prostatic hypertrophy (non-cancerous enlarged prostate), with outflow obstruction (where something prevents the bladder from emptying completely). He was prescribed antibiotics which did not help with urination. On 22 October, he was instead prescribed alfuzosin, a medication used to treat enlarged prostate. The man said that the alfuzosin was helping.
18. On 19 November, he refused to attend a hospital appointment for a prostate biopsy and cystoscopy (when a thin flexible tube with a light and lens is passed up the urethra into the bladder). It is unclear exactly why the man refused to go to the appointment, although he told prison staff that he was not due another appointment for six months. Hospital staff noted that his raised protein level alone gave him a 30 per cent chance of having underlying prostate cancer. A member of healthcare staff explained this to him.
19. After negotiation between the hospital and prison healthcare staff the man was re-referred to Pinderfields hospital on 4 February 2010 for further exploration of his problems urinating. Following his appointment later that month, a hospital consultant, wrote to the Wakefield healthcare department at the end of February. He explained that he had made a provisional diagnosis of T2/3 prostate cancer. (T2/3 refers to the stage of the cancer. T2 means that the cancer has not spread beyond the prostate gland, however, T3 indicates that it has broken through the prostate gland covering and may be spreading into the tubes which carry semen.) He said that the left lobe of the man's prostate felt malignant and he had arranged for a biopsy (where cells are taken from the possibly cancerous area and sent for further testing) and a cystoscopy. He wrote that he had told the man that he “may well have cancer”.

20. Officer A spoke with the man about his condition. He made an entry in his personal electronic record that the man had not been his normal self since the hospital appointment, which was understandable. The officer noted that the man's friend was keeping an eye on him.
21. Shortly after his urology appointment, the man developed a severe bone infection as a result of a diabetes related ulcer on his foot. (Diabetes sufferers often have problems with their feet and the man was regularly monitored by a foot specialist.) The infection was treated by antibiotics and was resolved in June.
22. At the end of March, the man told healthcare staff that he was experiencing urinary incontinence. He was provided with pads to wear, but he said that they were not adequate. The pharmacy at Wakefield arranged for more suitable pads to be supplied.
23. On 27 April, one of the prison doctors, made an entry in the man's medical record noting that the hospital consultant had told the man that he would need to have a catheter fitted. (A catheter is a soft plastic tube which is inserted into the urethra and drains urine from the bladder into a bag). Wakefield nursing staff agreed to catheterise the man. They explained the procedure and possible complications to him and first catheterised him on 11 May. He suffered from frequent blockages and infections over the following weeks that were adequately treated by healthcare staff.
24. The man went to hospital on 19 July for the cystoscopy, ultrasound scan and biopsy of his prostate. The hospital wrote to the prison on 22 July outlining the results of the cystoscopy and ultrasound. The results were "in keeping" with the diagnosis of T2 prostate cancer. However, hospital staff noted that the results of the biopsy were not yet available. The results, which were forwarded to the prison on 9 September, confirmed that his prostate cancer was a highly aggressive type.
25. The clinical reviewer concludes that the initial referral to the prostate clinic was made under the two week rule. (According to this rule, healthcare staff in prisons and in the community should refer any patient they suspect may have cancer to a specialist within two weeks. The rule helps to ensure that the patient receives prompt treatment.) However, because the man initially refused a further appointment, further investigations and the eventual confirmed diagnosis were delayed.
26. According to National Health Service (NHS) guidance, patients should generally not wait more than two months between referral by a doctor and receiving treatment for suspected cancer. The man waited five months. The clinical reviewer concludes that the biopsy and other investigations which confirmed the cancer diagnosis could not be carried out until the man's other health problems had been resolved. He notes that the hospital consultant and the prison doctor remained in contact between the provisional and confirmed diagnoses.

27. Had the man attended the original biopsy appointment in November 2009, perhaps the specialists might have begun treating the cancer sooner. However, it is not possible to say whether the outcome would have been any different if the biopsy been carried earlier.

Informing the man about his condition and treatment

28. In February 2010, the man was told that he may well have prostate cancer. This was not confirmed until September when the biopsy was done. On 21 September, the prison doctor talked through the results of the biopsy with the man in his cell. The man said that he knew that he had cancer and that during an appointment in March he had been told by doctors that he was not suitable for surgery and chemotherapy was the best medical option for him. The man told the doctor that he did not want chemotherapy and preferred to have surgery. The doctor advised him to discuss his options in more depth at his next hospital appointment.
29. The man had a hospital appointment on 30 September, during which he discussed his treatment options. He said that he wanted surgery to remove the prostate gland, with hormone therapy and radiotherapy as a second option. He was given information leaflets to take away with him so he could research and think about his options in more detail.
30. On 13 October, the hospital cancer specialist wrote to her colleague regarding the man's treatment options. She noted that she and the man had discussed treatment options, but that he was now disputing this. The man said that he had been told about chemotherapy, but not radiotherapy and that he was still keen to have surgery. The cancer specialist wrote that she had explained to the man that hormone therapy and radiotherapy were the most appropriate treatment options. However, she agreed that, as he was suffering with urinary problems as well, surgery might improve the quality of his life. The man was given the opportunity to ask questions and was put on the list for surgery.
31. The man went to hospital for surgery on 26 November. However, the operation was cancelled. A letter from the hospital explained that staff had advised the man that surgery was not the best treatment option for his cancer after all and he agreed not to have the operation. He started hormone therapy the following week and an appointment was arranged to start radiotherapy.
32. An entry in the man's medical record on 22 February 2011 notes that he was to start chemotherapy soon. On 17 March, the man spoke with a prison nurse about radiotherapy. The nurse noted in his medical record that he appeared jaundiced. The man told the nurse that he was worried about the radiotherapy treatment. The nurse reassured the man and offered him support. He said that he did not discuss his feelings with his peers, but would talk to staff if he felt anxious. The next day, the nurse recorded that she had conducted a depression screening, during which the man had said that he was not sleeping well because of his catheter. He said that he did not have much of an appetite as he felt sick and so anti-sickness medication was prescribed. The man denied feeling suicidal, although the nurse noted that he had a tendency to bottle up his

feelings and did not have any contact with his family through his own choice. The clinical reviewer notes that screening the man for depression following his diagnosis was an example of good practice.

33. The man was due to start radiotherapy on 30 March, however as he was still suffering from jaundice, the course of treatment was delayed to enable him to undergo tests to establish a cause.
34. The man had an ultrasound of his abdomen on 6 April. His condition had deteriorated, he had lost weight, the jaundice appeared worse and he seemed weak, with some shortness of breath. Blood tests showed he had an abnormal liver and kidney function. On 8 April, prison healthcare staff discussed the man's condition with him and he agreed to be urgently admitted to hospital. Later that day, healthcare staff noted that the cancer might have spread to his pancreas. (The man did not return to Wakefield again prior to his death in May.)
35. On 14 April, the man had a computerised tomography (CT) scan (which produces a three dimensional image of the body). The results of the scan showed that he had pancreatic cancer and he needed to be transferred to St James's Hospital for surgery. It was noted that his condition was unstable.
36. The man told staff that he did not want any further treatment and wanted to return to Wakefield to "let cancer take its course". However, following discussions with hospital staff, he decided not to discharge himself over the weekend and agreed to discuss his options again the following Monday.
37. A bed became available at St James's on 22 April. The man was transferred and a tube was inserted into his stomach to feed him. Hospital staff noted that he needed to be stronger if he was to undergo surgery. On 2 May, the feeding was discontinued as he was suffering from diarrhoea and antibiotics were administered via an intravenous line. There were no current plans to discharge him.
38. The man continued to ask to return to Wakefield and wanted to go back to his wing. A palliative care nurse had a long conversation with the man on 9 May. He told her that he did not want to have chemotherapy and appeared to have a good insight into his condition, wanting "life to take its course". The man was refusing medication and was also suffering from an infection in his abdomen. He man told hospital doctors that he did not wish to be resuscitated. He started to receive pain relief and anti sickness medication intravenously and he appeared comfortable and lucid.
39. The man continued to receive medication intravenously over the coming days, however his condition deteriorated and he died in St James's Hospital.
40. The clinical reviewer and we agree that, once the cancer had been diagnosed, it seems the man received considerable information about his condition and the best course of treatment. From the evidence available it appears that he was fully involved in the treatment decisions made. We are pleased to note that

prison healthcare staff provided him with a great deal of support, even once he had been admitted to hospital.

The man's medical appointments and treatment of the prisoner

41. In November 2009, the man refused to attend hospital for a planned biopsy and cytосcopy. Although the exact reason for the refusal is not clear, at some point during his treatment, the man told Officer A that he did not want to go to hospital to have a biopsy, as he did not want an officer to be present during such a personal appointment. The officer explained the security reasons for an officer to be present and urged him to engage in medical treatment.
42. With support and encouragement from staff, the man later attended diagnostic hospital appointments and consultations. He was not able to attend one appointment as it was cancelled by healthcare staff (the reason for the cancellation was not recorded), however this was rescheduled and he attended all further appointments.
43. Healthcare staff at Wakefield were able to meet the man's medical needs and provided him with the appropriate medication and care required to help manage his symptoms of prostate cancer and then, also, some months later pancreatic cancer.
44. The clinical reviewer notes that the man's medical record shows evidence of clear and frequent written and telephone communication between the prison and the hospital. He also notes that, while a prisoner, healthcare staff were "attentive" to the man's needs.

The man's pain relief and medication

45. Once his catheter had been fitted in May 2010, the man suffered from repeated blockages and urinary tract infections. He was appropriately cared for by healthcare staff and was prescribed various antibiotics to treat the infections.
46. In February 2011, the man began complaining of pain around the area of his prostate gland. He was prescribed opiate based pain relief medication as a result. The man complained of increasing pain on 5 April, when his health was deteriorating. He initially refused to be admitted to hospital or to the prison inpatients unit, where his pain could be better managed but agreed to go to hospital three days later. Once at hospital, staff adjusted his pain relief medication. On 13 May, he began to be prescribed morphine (a very strong opiate based pain medication, frequently prescribed to patients suffering with cancer).
47. The clinical reviewer and we are satisfied that prison healthcare staff prescribed appropriate pain relief to help minimise his symptoms. Once he began to engage in hormonal therapy, he was also provided with the appropriate medications and anti-sickness drugs that he required.

Liaison with the man's family

48. On 18 March 2011, the man discussed contact with his family with the nurse. She recorded that the man was not in touch with his family, by his own choice, and had not been for many years. The following month, prison staff visiting the man in hospital asked if he would like his next of kin to be contacted. The man said that he did not want them to know he was ill and refused to give any contact information.
49. In May, the man told hospital staff that he did not wish to be resuscitated should his heart stop beating. Again, staff asked him if he wanted his next of kin to be contacted. He said that he did not want staff to make contact with them while he was alive, but agreed that they could be approached after his death. He provided staff with contact details for his sister.
50. After the man's death, the appointed family liaison officer attempted to contact the man's sister using the information he had provided. Unfortunately, she no longer lived at the address and despite extensive efforts, the prison family liaison officer could not trace any members of the man's family. The prison arranged the man's funeral, which was held at the prison.
51. Prison staff followed the man's clear instructions and did not attempt to contact his family until after his death. He had not been in touch with any family for some years and the contact information was out of date. We do not think the prison could have done any more to try to locate and inform his family after his death.

The man's location

52. The man remained in his cell on normal location until 8 April, when his condition deteriorated and he had to be urgently admitted to hospital to undergo tests to establish a cause for his jaundice. The man was happy to stay on his wing as he felt comfortable, had friends and was familiar with staff, in fact he repeatedly insisted that he remain on the wing. I am satisfied that this did not affect the quality of care that the man received as he was able to self care and was fully mobile. He was able to self administer his medications and attended the treatments hatch and the healthcare centre as and when he needed to. I am pleased that both healthcare and discipline staff supported the man in his choice.
53. Following the diagnosis of inoperable pancreatic cancer in April 2011, the man was admitted to hospital as an inpatient, where he remained until his death. He told staff on more than one occasion that he wanted to return to Wakefield, despite being very ill. After discussion, he agreed to remain an inpatient where he could receive the most appropriate care.
54. The prison and hospital considered whether the man should be moved to a hospice towards the end of his life. They concluded that this would not be possible because the local hospice had previously expressed concerns about

accepting prisoners. He was told he would remain in hospital on 11 May and seemed to accept and understand the news.

Compassionate release

55. Prison Service Order (PSO) 6000, chapter 12 sets out the grounds on which a prisoner may apply for early release on compassionate grounds. Early release on medical grounds can be considered when the prisoner's condition is known to be terminal and death may occur soon. However, even when this is the case, consideration must be given to the likelihood of the prisoner committing further offences. In addition, there must be adequate arrangements for the prisoner's care and treatment once they are released.
56. During the investigation, the investigator spoke to the healthcare centre manager. He explained that, due to the nature of the offences most prisoners at Wakefield had committed, it was very rare for them to be granted release on compassionate grounds. He said that, even towards the end of his life, the man still posed a risk to the public because of the nature of his offending behaviour.
57. It is my view that, because he had no links with family or friends who could visit and support him, the man was not suitable for compassionate release. The fact that he remained a prisoner until his death meant that prison staff were with him 24 hours a day (known as bedwatch). While bedwatch is primarily a security measure, it can also offer support and company to a dying prisoner. In addition, several prison governors and healthcare managers visited the man while he was an inpatient.

Palliative care plans

58. Palliative care is the provision of holistic care to someone with a life threatening illness. The goal of palliative care is to provide the patient and their families with the best quality of life. It includes giving appropriate pain relief, offering psychological and spiritual support and offering support to the patient's family.
59. Having been diagnosed with pancreatic cancer, the man was admitted to Pinderfields Hospital on 8 April, to undergo surgery. He was transferred to St James' Hospital on 22 April. Hospital staff decided that he was too weak to be operated on and on 2 May, discussed end of life care with him. He died ten days later.
60. The clinical reviewer notes that, during that ten day period, the man could have continued to receive treatment for his cancer. However, he met the palliative care nurse on 9 May. During his meeting with the palliative care nurse, the man said that he did not want to receive any further treatment and wanted "life to take its natural course". The man said that he did not want to be resuscitated if he stopped breathing. He told the nurse that he did not want to receive any further medication. It is not clear if the hospital put in place a formal palliative care plan prior to his death.

Restraints, security and bed watch

61. Whenever a prisoner leaves the prison for any reason, a risk assessment must be carried out. The risk assessment considers the risks posed by the prisoner to staff and members of the public. The results of the assessment help staff to decide how many staff should accompany the prisoner and what level of restraints (for example, handcuffs) need to be applied. If a prisoner is admitted to hospital as an inpatient, they will normally be accompanied by prison staff, and this is known as a bedwatch. The prisoner will be accompanied by bedwatch staff 24 hours a day.
62. During routine diagnostic hospital appointments and consultations, two escort officers accompanied the man and he was handcuffed to an officer. The level of restraints was appropriately reduced so that the man could comfortably undergo medical tests and to give hospital staff proper access to him. On these occasions, an escort chain was used. (This is a length of chain with a handcuff at each end. The prisoner wears one cuff and a member of staff the other.) Handcuffs were normally reapplied once the tests were finished.
63. When the man was initially admitted to hospital to undergo tests to establish the cause of jaundice, he was accompanied by two officers and an escort chain was used. Restraints were again reduced to enable hospital staff to provide appropriate care to the man and so that treatments were not restricted. On 23 April, his condition began to deteriorate and the Duty Governor authorised the removal of all restraints to provide the man with comfort and dignity.
64. Bed watch logs during the time that the man was in hospital were completed appropriately and sensitively. Recordings were made regularly and all relevant information was included. Writing was legible and it was clear to see who had made the entries and at what time.
65. We are very pleased that Wakefield staff appropriately assessed the level of risk posed by the man. We often comment that prison staff are reluctant to remove restraints and they often do not do so until shortly before the prisoner dies. We commend staff for deciding to remove his restraints as soon as his condition deteriorated, even though that was several weeks before his death.

CONCLUSION

66. During the man's time at HMP Wakefield, he had regular meetings with doctors and healthcare staff and attended outside hospital appointments. He was treated appropriately according to his symptoms and his appointments, diagnosis and treatment were all documented well within his medical record.
67. Following the man's abnormal blood test results, appropriate actions were taken to establish a cause for the abnormalities and to ensure that timely appropriate care was available. There was a good level of communication between the man, prison staff, hospital staff and consultants.
68. The clinical reviewer concludes that the man received a good standard of care, equitable to that he might have expected in the community. We make no recommendations as a result of this investigation.