



**Investigation into the circumstances surrounding the
death of a man
in June 2011 while in the custody of HMP Leyhill**

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

June 2012

This is the report of an investigation into the death of a man. He had been suffering from lung cancer when he died in HMP Leyhill in June 2011. He was 70 years old. I would like to express my condolences to all who have been touched by his death.

The investigation was undertaken by one of my senior investigators. I would like to thank the Governor of HMP Leyhill and his staff for their co-operation. The local Primary Care Trust (PCT) Cluster commissioned a clinical reviewer to undertake a review of the man's clinical care. One of my family liaison officers contacted the man's daughter to explain the purpose of our investigation. I apologise for the delay in issuing this report.

In late January 2011, the man saw the prison doctor and reported having difficulty swallowing. He was referred for tests, and was found to be suffering from inoperable lung cancer. He remained in Leyhill until he died in June.

The clinical reviewer notes that the man received a high standard of care in Leyhill, and the investigation has identified a range of examples where staff efforts deserve commendation. Overall, both healthcare and discipline staff at Leyhill displayed a most caring and professional attitude.

Two recommendations are made in this report. The first seeks to ensure clarification of confusion over NHS funding arrangements for some of the equipment and services needed for the man. Staff ensured that this did not impact on him, but it needs to be resolved for the future. The second recommendation addresses the need to always have an effective point of contact for the families of terminally ill prisoners. I am pleased to note that both recommendations have been accepted.

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

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SUMMARY

1. The man was an elderly man, serving a long prison sentence. He had been in HMP Leyhill since 2002.
2. Following complications with surgery, the man had to undergo amputation of his left leg on 8 October 2010. He returned to Leyhill ten days later. He was able to move around the prison in a wheelchair, and seemed to make a good recovery.
3. In late January 2011, the man complained to the prison doctor of having trouble swallowing and of weight loss. He was referred to hospital for tests. Before an appointment could be made, however, his health deteriorated and he was taken to hospital as an emergency admission on 9 February. Tests revealed that he had lung cancer.
4. He was told that the cancer was inoperable. He began a course of palliative radiotherapy. (Palliative care is provided when patients will not recover from their illness, and are receiving treatment to reduce the severity of their symptoms.) He indicated that he wanted to stay at Leyhill for as long as possible. Contact was made with the local hospice, and expert care was brought in.
5. Healthcare staff saw the man daily. Weekly multidisciplinary meetings were held to discuss his care. There were some issues over which health authority had overall responsibility for his care, but healthcare staff in the prison pursued his best interests well, and equipment was obtained as required. Expertise was brought in to ensure that his care was correctly provided.
6. As his condition deteriorated, the wing Senior Officer gave up his office so that it could be converted to a comfortable room for the man. His friends in the prison were allowed to visit him outside usual hours, and agency nursing staff were brought in to provide the level of care he needed.
7. Having been out of contact with his family for some years, as the man reached the end of his life prison staff contacted his younger daughter. She visited him in prison shortly before he died. After he died, arrangements were put in place to provide support for staff and prisoners if required.
8. A post mortem was carried out on 16 June 2011. The doctor concluded that the man's death was due to lung cancer.
9. He received a very good level of care from Leyhill. I make two recommendations. The Head of Healthcare should ensure that the problems with overall responsibility for healthcare provision have been adequately addressed, and the Governor should ensure that families have reliable means of contacting the prison.

THE INVESTIGATION PROCESS

10. This 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 the 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?
11. HMP Leyhill provided the Ombudsman's investigator with the man's prison record, including his medical records. He visited the prison and met with the Governor and other members of the senior management team, as well as the Chair of the Independent Monitoring Board (explained later in the report). He spoke to staff and prisoners who knew the man.
12. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. Two prisoners asked to speak to the investigator, and he interviewed them both.
13. The police conducted an investigation into the circumstances surrounding the man's death, which is usual when someone dies in prison. The police found no suspicious circumstances.
14. The local Primary Care Trust (PCT) cluster conducted a clinical review of the man's care and treatment. Unfortunately, there were some problems with communication, and the commissioning of the report was delayed. Once arrangements were put in place, the review was undertaken by a clinical reviewer. This delay in commissioning the clinical review has impacted on the timeliness of this report.
15. The investigator interviewed three members of staff, two prisoners, and the Chair of the Independent Monitoring Board. Notes were made of these interviews and were sent to the interviewees to confirm their accuracy. The investigator provided feedback to the liaison officer at Leyhill during the investigation.
16. One of our Family Liaison Officers contacted the man's daughter to explain our investigation and offer the opportunity to contribute. She felt that her father had received exemplary care in the prison throughout his illness. She did, though, have some difficulty in being

able to speak to anyone at the prison on the telephone after visiting her father. She was provided with a copy off the draft report and did not raise any further issues in response.

17. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Throughout the course of the investigation, the investigator remained in contact with the Coroner's office. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

HMP LEYHILL

18. HMP Leyhill is a category D prison in South Gloucestershire. Category D (known as open) prisons, hold prisoners who require only the minimum security. Formerly a wartime hospital, Leyhill was rebuilt in the 1980s to house prisoners. New accommodation units were added in 2002, and the prison now has a capacity to hold 532 prisoners.
19. Healthcare cover is provided in Leyhill Monday to Friday, 7.30am to 4.30pm. Doctors are in the prison for half of each of those days, when they run GP surgeries. These are usually, though not exclusively, in the mornings. If a doctor is required out of hours, the local surgery provides cover.

Previous deaths at Leyhill

20. Since this office took over responsibility for investigating deaths in prison custody in 2004, the man's is the first death in Leyhill. There has since been one further death.

Her Majesty's Inspectorate of Prisons' report

21. The last report published on Leyhill by HM Chief Inspector of Prisons followed an unannounced inspection in May 2010. The report noted that health services in the prison were good.

Independent Monitoring Board (IMB) report

22. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The annual report published by the IMB for Leyhill before the man died noted that despite staffing difficulties, healthcare staff delivered an "excellent service" to prisoners.

ISSUES

The diagnosis of the man's terminal illness

23. Having undergone an amputation in October 2010, the man remained in regular contact with the healthcare team at the prison over the ensuing weeks for aftercare.
24. On 26 January 2011, the man saw the prison doctor and complained of difficulty swallowing, as well as weight loss. The prison doctor examined him and could not identify any further problems. Nevertheless, he did make an urgent hospital referral. An appointment was set for 18 February.
25. In the interim, the prison doctor kept the man under observation. He saw him on 7 February, and his condition was deteriorating. He saw him again on 9 February, and his condition had worsened. He was not eating, and the doctor took the decision to send him to hospital. He was admitted to hospital as an emergency patient.
26. As part of the hospital investigations into his health, the man underwent a magnetic resonance imaging scan. Known as MRI, these scans use strong magnetic waves to produce detailed internal pictures of the body. His scan showed an unidentified mass in his chest which required further testing. These tests were undertaken while he was still in the hospital, and revealed cancer.
27. Having had an amputation in October, the man had a good level of contact with healthcare. No serious deterioration in his condition was noted, nor did he raise any health concerns that could have alerted staff to his subsequent diagnosis. When he complained to the doctor in late January that he was having difficulty swallowing, he also said that he had lost weight. At that stage, the weight loss was only marginal. The clinical reviewer notes that the doctor's examination of him was thorough, but did not uncover any further apparent problems. The doctor still referred him to hospital under the urgent referral system.
28. Even with the urgent referral appointment pending, when the man presented with deterioration in his health, he was sent to hospital as an emergency admission before the appointment was due. It was at this time that his cancer was identified.
29. The clinical reviewer comments that the doctor's assessment of the man in prison was thorough. He was referred for an urgent appointment. His health was monitored in the meantime and when necessary he was admitted to hospital. It was here that his cancer was detected. It seems that he received appropriate care from the prison healthcare team, and that there were no undue delays in the diagnosis of his illness.

Informing the man about his condition and treatment

30. Having been discharged back to Leyhill on 15 February, the man returned to hospital for a scheduled appointment on 21 February. It was at this time that he was told that he had been diagnosed with lung cancer. He was told that the disease was inoperable, but the available treatment options were explained to him. His friend in prison said that he accepted the diagnosis and was aware that it was terminal.
31. A multidisciplinary team meeting was held on 23 February to discuss the man's care. The meeting recommended a course of palliative radiotherapy. (Palliative care is provided when patients will not recover from their illness, but are receiving treatment to reduce the severity of their symptoms.)
32. On 28 March, the prison doctor discussed the question of resuscitation with him. The man said that if the situation arose whereby it was necessary, he did not wish to be resuscitated. He signed a form confirming his wishes, and copies were kept in healthcare, on his wing, and at the prison gate. The local ambulance service was also informed.
33. Prior to his diagnosis, the man had not had many dealings with the chaplaincy. Afterwards, he became more engaged. He accepted sacraments, a deacon saw him twice a week or more and someone from the chaplaincy saw him at least every other day.
34. When the local hospice became involved in the man's care, he had to agree to disclosure of his records. Two IMB members oversaw his signing of the papers, ensuring that he understood the disclosure process.
35. The man's cancer was inoperable. He was informed at a scheduled hospital appointment, when the treatment options were explained to him. This was followed by a multidisciplinary meeting two days later to consider his care. The difficult issue of resuscitation was openly discussed with him and his wishes respected. The information provided to him and the timeliness involved appears appropriate.

The man's medical appointments and treatment

36. After his initial diagnosis, the man received follow-up treatment from the oncology (cancer) department at hospital. He received one treatment of palliative radiotherapy in an attempt to freeze his tumour. The attempt was unsuccessful, and the hospital said that they could not provide any further treatment.
37. In Leyhill, the man was seen daily by healthcare staff. These checks were usually in his cell, with occasional visits to the healthcare

department. As his illness progressed and he became weaker, the visits to the healthcare department decreased.

38. The Deputy Governor chaired multidisciplinary review meetings on a weekly basis to assess the man's care. These meetings incorporated both healthcare and discipline staff, as well as other departments who had contact with him. This included representatives from the library and the chaplaincy.
39. In March 2011, three prisoners in Leyhill were confirmed as having norovirus (an infectious group of viruses that can infect the stomach). The man told staff that he had been suffering from nausea. Staff kept him under observation, and it was confirmed that he was not suffering from norovirus. His symptoms had subsided within a few days. The Chair of the IMB told the investigator that there had occasionally been problems with the prison's capacity to provide escorts for visits to outside hospital, but this had not affected him.
40. Once contact had been made with the local hospice, the man was assigned a care nurse. She visited him in the prison once per fortnight. She brought expertise in caring for someone with his illness, and this allowed the prison to obtain whatever equipment proved to be necessary. The prison already had a hospital bed, but a foam mattress was supplied to help him with his comfort. When a syringe driver was required for his pain relief, this was obtained without any difficulty. (A syringe driver is a small, portable battery-driven infusion pump, used to give medication gradually via a syringe.) On the Friday before he died, when his condition began to deteriorate rapidly, staff obtained an air mattress to make him as comfortable as possible.
41. When the man was initially diagnosed with cancer, healthcare staff worked beyond their normal working arrangements. They worked longer days, and came into the prison outside their normal working hours. Staff from a team of palliative care nurses and healthcare assistants also came in to see him every day. By 2 June, when he needed fuller care, arrangements were made to provide night cover and agency nurses were brought in to provide this service.
42. There were some administrative difficulties around responsibility for the man's healthcare. Staff at the prison had difficulty in confirming whether prisoners at Leyhill were the responsibility of Bristol Community Health or NHS South Gloucestershire. There were issues around obtaining equipment and funding. Throughout, staff in the prison pursued his best interests swiftly and managed to obtain whatever was required. We make no criticism of the staff at Leyhill, indeed there is much to commend. However, the issues concerning which part of the NHS is responsible for what should be addressed as such confusion risks being the cause of significant problems. The Head of Healthcare has tried to make sure that the situation is

resolved, and should ensure that formal protocols are in place to clarify responsibility. We support this with the following recommendation:

The Head of Healthcare should ensure that protocols are in place with the NHS locally to clarify lines of responsibility for Leyhill, so that effective treatment and care of prisoners is maintained.

43. It appears that the man received a good level of treatment in Leyhill. As soon as his illness was diagnosed arrangements began to address his needs. Staff worked beyond their normal remit to provide the care he needed. Multidisciplinary meetings considered his needs on a weekly basis. Expertise from a local hospice was brought in and whenever equipment was needed it was provided. The IMB visited him regularly, and the IMB's Chairperson told the investigator that the man only had positive comments to make about his treatment.

The man's pain relief and medication

44. Throughout his illness, the man frequently complained of constipation. Healthcare staff prescribed appropriate medication, although he was reluctant to take it. The problem was often addressed using enemas.
45. On 12 May, the man said that his pain had increased. He was assessed by a doctor in his cell, and found to have a raised level of white cells (which can be a sign of infection). The doctor prescribed antibiotics for a chest infection. At this stage, he also asked him if he wanted a blood transfusion if this became necessary due to his cancer. He said that he did not.
46. It was also at this point that the doctor prescribed morphine as pain relief. The medication was kept in a safe in the man's room, although he frequently had to be reminded to take it. As a result, on 16 May Fentanyl patches (which are put on the skin and release medication into the system slowly over a number of days) were prescribed to help with pain relief. Towards the end of his life, a syringe driver was used to deliver pain relief to him.
47. The two of the man's friends who were interviewed by the investigator said that he was given good treatment. They both said that the nurses had looked after him, and if he required a nurse when none were on duty then outside nurses were with him within 15 minutes. They also both commented that his pain had been well controlled.
48. The clinical reviewer notes that, as is often the case with such an illness, a variety of medications and approaches was required. Staff dealt with challenging symptoms with tenacity. It seems that the man's medication was well managed.

Liaison with the man's family

49. The man had been in prison for a number of years and had been out of contact with his family through that time. At the end of May, knowing the extent of his illness, he said that he would like to contact his family. Staff at the prison therefore contacted his youngest daughter. This was initially instigated through the victim liaison officer.
50. The man's daughter visited him in the prison on 10 June. Thereafter she agreed to act as next of kin for her father. She told our family liaison officer that she was content with her dealings with the prison and with her father's care.
51. While in the prison, the duty governor gave the man's daughter a telephone number to contact in future. She would speak to either a Governor or a Senior Officer (SO). However, when she called this number the following Sunday, she was told that nobody at the prison would take the call and she should contact victim support. This caused her a degree of distress.
52. The investigator raised this issue with the prison. The man's daughter had already done so, and the prison had been in contact with her. They were unable to identify who she had spoken to. If the contact number she had been provided with was not covered, the calls would only be routed to the communication centre or the gate. However, the only staff on duty at that time had been male, and she said that she had spoken to a female.
53. It is possible that the man's daughter had connected to an external switchboard, covering other prisons as well as Leyhill. Operators there would have been unaware of who she should be connected to if the extension she required was unavailable. Nevertheless, she was going through a very difficult time and should have had support. There is no doubt that staff in Leyhill were sensitive to her position, and did their best to provide that support. In future, staff liaising with the families of terminally ill prisoners should ensure that they have a means of contacting someone when necessary.

The Governor should ensure that, if the nominated family liaison officer is unavailable, alternative arrangements are in place to maintain effective support for the families of terminally ill prisoners.

54. The man's daughter provided a telephone number and asked that she be contacted when her father died. The prison ensured that this happened.
55. In line with the Prison Service Order addressing deaths in custody, Leyhill offered financial assistance for the man's funeral. This was held in the prison, then at a local crematorium. His daughter confirmed that all her father's possessions had been returned to her.

The man's location

56. A meeting was held on 25 March to discuss the man's location. Attendees included healthcare staff, the residential governor and his oncology nurse. The meeting discussed the available options.
57. The prison considered whether the man should transfer to HMP Bristol or Norwich, which have units experienced in dealing with seriously unwell prisoners. The residential governor discussed this with the Offender Health Developmental Manager for the South West, and they agreed that, if it was his wish, it would be beneficial for him to remain in the familiar environment of Leyhill for as long as possible.
58. Contact was made with the local hospice on 4 April. As a result the hospice's clinical director and one of their community nurse specialists visited the prison on 7 April. The man said that he wanted to remain at Leyhill. The clinical director asked him what accommodation arrangements he wanted for when his life was nearing its end. He said that when that became the case, he wanted to go to the hospice. However, as his illness progressed and he was cared for by prison staff, he was content to remain where he was, and did not pursue his request to go to the hospice.
59. As the man's illness progressed, palliative care nurses were brought in to look after him. He was moved to a bigger room, and staff made arrangements so that his friends could sit with him and keep him company. He had initially mentioned going out to a hospice, where his pain could be better controlled. He later, though, changed his mind and said that he wanted to remain in Leyhill where he had friends and was part of the community.
60. At the end of May, it was agreed that it was no longer appropriate for the man to remain in his cell. The wing's Senior Officer agreed to give up his office and allow it to be adapted to accommodate him. The room is spacious, and quiet compared to the ordinary wing. He had seriously restricted mobility and would be largely confined to the room so a television was supplied, and an additional digital box was acquired to expand the number of channels available to him to stop him from becoming bored. Two weeks before he died, staff made special arrangements so that he could have a friend sit with him through the night.
61. The man's location was given early consideration once it was known that he was suffering from a terminal illness. A multidisciplinary meeting considered the options, and contact was made with outside agencies. The local hospice, who have experience in dealing with his illness, were involved at an early stage. It was his wish to remain in the familiar surroundings of Leyhill, and the prison was able to provide appropriate care. It is particularly commendable that the wing Senior

Officer willingly allowed his office to be given over to him. His friend told the investigator that he was comfortable in his new surroundings. Agency staff were brought in to ensure that he had support available and was thus able to remain in Leyhill until the end of his life.

Compassionate release

62. When the man was first diagnosed, staff considered a transfer to the elderly lifer unit at HMP Norwich. He did not, though, meet their criteria. The prison then discussed the possibility of his early release on compassionate grounds, and began the application process.
63. Reports were gathered from those involved in his care, including a healthcare assessment and a specialist consultant's diagnosis. Once reports had been received from the man's offender supervisor and psychologist and it was clear that such an application would be supported, the issue was raised with him himself. However, he said that he did not wish to be released. The process was therefore suspended.
64. The man's solicitor contacted the prison on 10 June. She asked for a legal visit, and to request his release on compassionate grounds. The visit was arranged for 13 June, when he confirmed to her that he did not wish to be considered for release.
65. It is clear that the possibility of release was considered. Before raising the issue with the man, and maybe raising his hopes, the liaison officer ensured that such an application would be supported. When subsequently raised with him, however, he said that he did not want to be released. The application went no further. This process was handled in a sensitive way.

Palliative care plans

66. As soon as it was clear that the man's illness was terminal, healthcare staff worked to ensure that appropriate care was provided. Contact was made with the Bristol Community Health Palliative Care Team and arrangements made for them to visit daily to attend to his personal care. This was provided daily up to and including the day he died. Early contact was made with the local hospice, and expertise was brought in. Arrangements were made to have both the Liverpool Care Pathway (a recognised continuous quality improvement programme for the care of a dying patient) and the Gold Standard end of life care pathway in place. However, as his care was consistent and adapted as his illness developed they were not put into action.
67. The man received ongoing care to a good level. Expertise was brought in as required. Although end of life pathways were not followed, he was assessed daily and treated appropriately. The clinical reviewer notes that in the last week of his life, community and agency nursing

staff provided 24 hour support to supplement the care he received from prison staff.

CONCLUSION

68. The man had spent a number of years in prison, many of them in Leyhill. He was an elderly man, not in the best of health, and had recently undergone a partial amputation of his leg. He was a heavy smoker, and continued to smoke through his illness.
69. When he presented to the prison doctor with a problem that could not be identified, he was referred without delay for tests. He was given an urgent appointment, but before that date he became unwell and was sent to hospital as an emergency admission. It was during this stay that he was diagnosed with inoperable cancer.
70. From this point on, prison and healthcare staff provided close and ongoing support. The clinical reviewer notes that the medical records detail “frequent attentive medical, nursing and social care of a high standard from the Leyhill Team”. Symptoms and pain were persistently and resolutely addressed, and equipment and expertise were brought in as required.
71. Staff worked beyond their normal requirements to meet the man’s wishes to remain in the Leyhill environment with which he was familiar. When his cell became inappropriate to his needs, a manager gave up his office to provide a comfortable space for him to live in. As he neared the end of his life, community and agency nursing staff were brought in to ensure the 24-hour support he needed.
72. The man’s friends commended the care he was given. An unsolicited section of the Listeners¹ report to the next Safer Custody meeting after he died commented on the impressive level of support staff had provided to him. The clinical reviewer comments that prison and healthcare staff should be praised for their treatment of him. We are similarly impressed by the level of support and professionalism displayed by healthcare and discipline staff alike. We commend all those involved in his care.
73. We make two recommendations. The first relates to the need for clarity with the NHS as to overall responsibility for healthcare provision for prisoners at Leyhill. The second relates to ensuring consistent contact points for the families of terminally ill prisoners.

¹ Listeners are prisoners selected and trained by the Samaritans to provide a confidential emotional support 24 hours a day to fellow prisoners in distress.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that protocols are in place with the NHS locally to clarify lines of responsibility for Leyhill, so that effective treatment and care of prisoners is maintained.

This recommendation was accepted. The Head of Healthcare arranged to meet with the Primary Care Trust Commissioner and Bristol Community Health to clarify lines of responsibility.

2. The Governor should ensure that, if the nominated family liaison officer is unavailable, alternative arrangements are in place to maintain effective support for the families of terminally ill prisoners.

This recommendation was also accepted. Another member of staff was identified for training, and a better communication system has been set up for instances where a family member needs to speak to a family liaison officer.