PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at HMP Durham in September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report of an investigation into the circumstances of the death of a man in September 2011, at HMP Durham. He was 69 years old. The cause of death was pulmonary abscess and pleurisy due to lung cancer. I extend my condolences to all those affected by his death.

The investigation was undertaken by an investigator. A review of the man's medical care in prison was commissioned from NHS County Durham and Darlington. HMP Durham cooperated fully with this investigation. I apologise for the delay in issuing this report.

The man had several pre-existing serious medical conditions when he arrived at Durham on remand in 2010, including diabetes, heart disease and mental health issues and had been under medical investigation for a possible cancer. Terminal lung cancer was later confirmed. Following his conviction in June 2011, he decided that he would accept no treatment other than palliative care.

A multidisciplinary team cared for the man during his illness. The investigation found that staff were responsive to his increasing needs and care was delivered sympathetically. Although early release on compassionate grounds was considered, the man expressed a preference to remain in prison among friends and staff he knew. I am satisfied that the man received a very high standard of care at Durham where he was treated with humanity and dignity by those who dealt with him. His eventual death was managed with sensitivity and in accordance with his wishes. I commend all those involved in his care.

Nigel Newcomen
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man, a 69 year old prisoner, at HMP Durham died from a pulmonary abscess and pleurisy caused by cancer of the lung in September 2011.

2. The man was remanded in custody in July 2010 and sentenced to seven years imprisonment in June 2011. He was in poor health and was treated for diabetes, heart disease and mental health issues. He was also undergoing medical investigation for a suspected cancer, which continued when he entered prison. He was a heavy smoker and remained so until his death.

3. In May 2011, a diagnosis of inoperable small cell carcinoma in the lung was confirmed. His prognosis was that he might live for three months without treatment and 12 months with it. The man refused treatment, although he accepted palliative care.

4. The man's care was provided as part of the North East Palliative Care Project and Durham implemented the Integrated Care Pathway for End of Life Care. The multidisciplinary approach within the Pathway ensured that all aspects of his welfare, medical and mental healthcare, social and spiritual care were all addressed, documented and acted upon.

5. The man was consulted and fully involved in all decisions affecting his treatment. He made it clear that he did not wish to be resuscitated in the event that he suffered a life threatening deterioration. He wanted to remain at Durham until his death, and to live on his residential wing until he felt he needed to transfer to the healthcare centre, or it was medically unviable to treat him properly in his cell. A mental competency assessment was made to ensure that he was capable of making those decisions. The man requested admission to the healthcare centre on 12 August, where his palliative care continued and intensified over the following weeks as his condition worsened.

6. The man died peacefully in the late afternoon of 8 September. A post mortem found that the cause of death was a pulmonary abscess and pleurisy due to metastatic small cell carcinoma of the right lung contributed to by diabetes mellitus.

7. The prison chaplain conducted memorial and funeral services. The latter was held at the local crematorium and attended by friends, members of the prison chaplaincy, wing and nursing staff. HMP Durham met the costs of the funeral and delivered The man's ashes and property to his nominated next of kin.

8. The investigation found that the man received an excellent standard of care and no recommendations have been made.

THE INVESTIGATION PROCESS

8. The investigator first visited HMP Durham on 10 October 2011. He was given a full briefing about the circumstances surrounding the man's death by the duty governor and the safer custody liaison officer. He viewed relevant parts of the prison, including the healthcare centre where the man died. He also met a representative of the Prison Officers' Association. No representative of the Independent Monitoring Board was available on that day.

9. Notices were issued to staff and prisoners, inviting anyone who might have information relating to the man to make themselves known to the investigator. No prisoners responded. The investigator met and interviewed relevant members of prison and healthcare staff. The delay in issuing this report is regretted. This was largely due to the late receipt of the clinical review.

10. One of the Ombudsman's family liaison officers wrote to the man's nominated next of kin to tell him about the investigation and to offer the opportunity to raise any concerns or questions that he wished addressed. His next of kin raised no concerns.

11. NHS County Durham and Darlington commissioned a clinical review, the final version of which was sent to the investigator on 19 March 2012.

12. The man's next of kin was informed the draft report was available, but did not wish to receive a copy or make any comment.

HMP DURHAM

13. HMP Durham is a local prison serving the courts of Tyneside, Durham and Cumbria. It holds up to 1017 men in seven accommodation wings.

14. Healthcare at HMP Durham is provided by Care UK on behalf of NHS County Durham Primary Care Trust. A full-time medical director and a general practitioner are both based at the prison. A local general practitioner practice provides on-site support from 5.00pm to 8.00pm daily and remotely until 10.00pm when the NHS County Durham out of hours service takes over. There is a pharmacy service. Durham operates the SystmOne computerised patient management system.

15. The Durham cluster of prisons, in conjunction with County Durham and Darlington NHS Foundation Trust and Macmillan Nursing, operate a multidisciplinary Palliative Care Project comprising medical and mental health specialists, nursing, spiritual and prison staff. The purpose of the project is to ensure that from the time a patient is diagnosed with an illness that is likely to end in his/her death, all their concerns and needs, including the potential aftermath of their death, are addressed and, where possible, resolved.

16. The Integrated Care Pathway (ICP) for end of life care forms part of the palliative care project. The aim of the ICP is to provide a practical guide to support prison, healthcare and social care professionals in delivering high quality end of life care to prisoners and it complements Department of Health and HM Prison Service guidance. It is a comprehensive approach which involves all departments within a prison and relevant external third party organisations. This process was used for the man's care.

HM Chief Inspector of Prisons

17. The most recent inspection by HM Inspectorate of Prisons took place in October 2011. Inspectors found that the care of patients with lifelong conditions, such as asthma, diabetes and heart disease, was good. The inpatient unit was clean and appointments at external hospitals were managed well and rarely cancelled. Additional mental health services were being put in place and there was an open referral system in which cases were allocated daily.

Independent Monitoring Board

18. All prisons have an Independent Monitoring Board (IMB) made up of members of the community whose role it is to ensure that proper standards of care and decency are upheld. prisoners are treated decently. In their most recent annual report the Board was positive about the project to develop and implement standards for cancer, palliative and end of life care across the HMP Durham cluster and the Macmillan Prison Project, which they said was producing excellent work especially for elderly prisoners.

Previous Deaths at Durham

19. There were three deaths at HMP Durham in the year before the man's death. None of the circumstances were similar to those of the man's.

KEY EVENTS

20. The man was 68 years old when, on 23 July 2010, he was remanded into custody at HMP Durham charged with serious sexual offences committed several decades before. This was not his first time in prison but his previous sentence was 41 years earlier. At the time of his reception, the man did not name a next of kin and had not been in contact with his family for many years.

21. The reception nurse and the prison general practitioner carried out an initial health screen with the man. He said that he used neither drugs nor alcohol and lived alone. He reported that he had suffered three heart attacks in the previous seven years and had undergone an angioplasty (an operation to repair a blocked blood vessel); he was no longer receiving treatment for this condition. The man had also undergone recent treatment for depression and had been diagnosed with type two diabetes, epigastric (the upper central region of the abdomen) pain and ischaemic (an inadequate supply of oxygen caused by blockage or constriction of the blood vessels) heart disease. His community doctor had told him that he might have cancer and had been referred for an endoscopy (an internal examination using a tube fitted with a camera).

22. The prison GP contacted the man's community doctor on 26 July to clarify his medical history and a request for his records was sent. The doctor prescribed several medications including amlodipine, aspirin, frusemide, glyceryl trinitrate and ramipril, all to treat high blood pressure, angina and heart failure. He was also prescribed gliclazide and metformin hydrochloride for his diabetes. As the man was received into custody with a suicide/self-harm warning, he was assessed and referred to the mental health team, although he had no thoughts of deliberate self-harm. The man was accommodated on E wing, Durham's first night centre.

23. A community psychiatric nurse (CPN) on E wing, reviewed the man on 27 July. He was anxious about being in prison and referred to some previous mental health care but confirmed that he had not been an in-patient. Although he was feeling in a very low mood, he said he had no thoughts of suicide or self-harm. The CPN gave the man a brief cognitive examination which revealed some deficits in his concentration and memory. She contacted his community mental health team the following day for further information and referred the man to a psychiatrist, for evaluation. An appointment was made for 18 August. The CPN planned a further review a week later and throughout the man's time at Durham, she carried out regular, usually fortnightly, mental health reviews. The psychiatrist also saw him regularly.

24. A letter from the man's community GP was received on 5 August, indicating that he had been referred for an upper gastro intestinal endoscopy for dysphagia (difficulty in swallowing or the feeling that food is lodged in the passage to the stomach). On 9 August, the prison doctor, made a further referral under the two-week rule. This is an urgent referral to hospital for patients with suspected cancer that ensures that a specialist sees them within

two weeks. An appointment was received for an endoscopy examination on 16 August.

25. The psychiatrist saw the man as arranged, on 18 August. The doctor considered he was suffering from an adjustment reaction (a mental condition following a stressful experience) with mood difficulties. He also noted a tremor in his hands that might have been due to dementia, which required further exploration. He prescribed fluoxetine, an antidepressant and made a further appointment for one month later.

26. A week later, on 25 August, the man attended the diabetic clinic for an annual review. The podiatrist noted some diabetes-related issues and made a further appointment for 12 weeks time to monitor him. He was given smoking cessation advice but was not interested.

27. Test results from his gastro intestinal endoscopy were received on 10 September, which concluded that there was significant gastritis (inflammation of the lining in the stomach). Gastric biopsies (removal of a small piece of the stomach for microscopic examination) and campylobacter-like organism (CLO) tests were taken. The remainder of the examination was reported as normal. Durham received the results from the additional tests on 14 September, which concluded that there was no evidence of a serious condition.

28. Between October 2010 and February 2011, the man had investigations for medical conditions including tremors, poor memory, mobility problems which were initially thought to be due to Parkinson's Disease, a hernia and gastritis. He was referred to a psychiatrist specialising in old age, as well as neurologist. Dementia was ruled out and propranolol was prescribed to alleviate the tremor. The man also had an annual heart disease review and monitoring of his diabetes. He was also given advice about his medications and managing persistent pain.

29. Due to side effects the doctor stopped the propranolol on 21 February. At the same consultation, the doctor noted that the man complained of a persistent cough and the occasional show of blood as a result. He noted that his chest was crackly in both lungs and planned for a chest X-ray, which was made for 2 March. Blood tests were also taken.

30. On 24 February, the man attended the diabetic clinic where he told the nurse that he felt tired all the time but was unsure why. She noted that he had had blood tests earlier that week and decided to await the results of them. She gave advice about smoking cessation and tried to discuss the risks associated with smoking and diabetes but he was unwilling to engage.

31. The chest X-ray results showed abnormal shadowing in the man's lungs. Medical staff thought it might be to be an area of infection but did not rule out the possibility that it was something more serious. Antibiotics were prescribed and a further X-ray scheduled for 17 March. The man had a coronary heart disease annual review on 8 March, which, except for an expected abnormal

white blood cell count, was within normal parameters. During his mental health review on 11 March, the CPN recorded that his physical health concerns were outweighing his mental health issues although he remained in a positive mood.

32. As a result of an error at Durham, the man missed his X-ray appointment on 17 March and he attended the following day. On 20 March, he reported a lump in his right groin to a nurse but was reluctant to let her examine him. Comparisons were made between the two X-ray results by a radiologist who advised that there was a suspicion that the shadowing in the man's lungs indicated a malignancy and strongly advised a referral to a chest specialist. The man was informed of this by a doctor and the referral was made the following day under the two week rule. An appointment was made for 5 April.

33. On 1 April, the man saw the CPN for a regular review and expressed concerns about his recent chest X-rays and his fear that he might have cancer. He also complained of persistent coughing, tiredness and general discomfort. A few days later, on 5 April, the man had a coronary heart disease review at the prison in which his medications and their side-effects were discussed. He was reminded about the use of his GTN (angina medication) spray and when and how to call for help if he suffered persistent chest pain. He was again offered smoking cessation advice, which he rejected and a depression screening was carried out.

34. The man also attended the hospital chest clinic the same day and was seen by a consultant in respiratory medicine, and a lung specialist nurse. The doctor explained it was likely that his symptoms were due to an underlying lung cancer. The man agreed to return to hospital the following day and underwent a series of tests, including a CT scan and a bronchoscopy (a fibroptic tube inserted into the airway) which medical staff stopped because he was unable to tolerate the procedure. He was referred to another consultant in respiratory medicine, for an endobronchial ultrasound (EBUS) (a bronchoscopic technique that uses ultrasound to visualise structures within and adjacent to the airway) and is less invasive. An appointment with the consultant was made for 3 May but was subsequently rearranged for 16 May, due to the man's attendance at court.

35. When seen by the CPN on 13 April for a mental health review, the man spoke, with some levity, about having cancer. He looked frail, dishevelled and was very short of breath and coughing violently on exertion.

36. A clinical team leader co-ordinating the provision of care for prisoners, introduced herself to the man on 17 April. She explained that when he went to the consultant's clinic a patient advocate would accompany him in case the diagnosis was complex. He was content with this.

37. On 6 May, a officer introduced himself to the man as his new Personal Officer. A few days later, at the suggestion of one of the prison doctors, he moved to the ground floor on C wing to make it easier for him to collect his food and medication. When the CPN saw him on 17 May, his main concerns were for

his physical health. Although he had not been given a formal diagnosis, he told the nurse he was prepared for the worst.

38. On 25 May, the psychiatrist discharged the man from his patient list leaving it open for him to be re-referred, if necessary. Arrangements were made for him to see the consultant in respiratory medicine on 26 May, to be informed his diagnosis. The clinical team leader contacted the Macmillan prison project lead, and it was agreed that she and the Community Macmillan Nurse would support him at the appointment. The prison Macmillan nurse also planned to contact Durham healthcare staff after the man's return to tell them of any relevant information, treatment plans and any follow up requirements.

39. The consultant in respiratory medicine gave the man the diagnosis of lung cancer, which they discussed. He was referred to the oncologist (cancer specialist). The prison Macmillan nurse telephoned the healthcare centre at Durham that evening to inform staff that the cancer was inoperable and that the man was aware of this. She thought his pain relief medication might be inadequate and would contact the clinical team leader.

40. The clinical team leader visited the man on C wing on 29 May and spoke to him about his diagnosis. His solicitor had told him that he could potentially be sentenced to 12 years imprisonment, so he was unsure if he wanted chemotherapy and felt he would rather die without treatment than endure a long sentence. During the conversation, he expressed the view that he would be better off taking all his medication at once. She told him that if this was a risk she would remove the medication held in his cell and he would receive his prescriptions daily from the pharmacy. They discussed the issue and the man assured the clinical team leader that he was not at risk of harming himself and that it was just a comment in reaction to his current situation. She told him he would be supported through his treatment and said he felt reassured.

41. The man refused the offer of admission to the healthcare centre, preferring to remain on C wing with staff he knew and where he had friends. The man told the clinical team leader that his pain control was fine but that he would discuss it with the doctor. She also agreed to arrange a fan for his cell.

42. The man had a review with the CPN on 31 May. He told her that he would not start treatment if he was sentenced, which was due the week beginning 13 June. He understood the consequences, but remained of the opinion that there was little point in accepting it in the face of a long sentence and was philosophical about the diagnosis. He strongly denied any intent to self-harm and remained in possession of his medication.

43. The prison Macmillan nurse visited the man on 6 June. They discussed his pain relief and the recent alteration to his analgesics. He was emotional during the interview and discussed his dilemma about accepting treatment before he was sentenced. The prison Macmillan nurse explained that treatment would be palliative but, at the time, the man did not fully understand this approach.

43. The palliative care options, including chemotherapy, were discussed with the man at the oncology clinic on 10 June but again he opted to wait until after sentencing to make a decision about whether to accept treatment. Over the following week the doctor adjusted his pain relief to include oral morphine (oramorph) and assessments were made in advance of a possible decision that he would consent to treatment. The CPN was concerned that the man did not understand what palliative care entailed. She also considered that the man was not well enough to attend court and discussed with the probation officer the possibility of an appearance by video-link. The clinical team leader spoke to the man again on 16 June about his lack of understanding of palliative care and promised that the prison Macmillan nurse would speak to him on Monday after his court appearance, for sentencing.

44. The man was sentenced to seven years imprisonment on 17June 2011. The clinical team leader went to see the man on his wing on Saturday 18 June and explained the use of oramorph for breakthrough pain should his normal medication fail to control it.

45. On 20 June, the oncologist's secretary telephoned to find out whether the man wished to have treatment now that he had been sentenced. He was unclear about the sentence he had received and made no decision at the time. He discussed his pain relief with the prison Macmillan nurse later that day and then appeared to have better understanding. She also reiterated his treatment options and informed him that a CT scan of his head had been arranged. A CT scan on 22 June was stopped because he vomited during the procedure.

46. The following day, a doctor and the prison Macmillan nurse reviewed the man in the prison chapel, which was easier for him than going to the HCC. The prison Macmillan nurse obtained a back support for the man to help him sleep in a prone position.

47. Macmillan and mental health nurses reviewed the man regularly and monitored his progress. On 30 June, he told the CPN, in their regular mental health review, that he was relieved that the court case was finished and that he would not accept treatment for his cancer. He said: "what is the point, I don't want to be here for the next seven years" and that he had no intention to take his own life but would let the illness take its course. His attitude was that as long as he was not in too much pain he would be all right and that he would like to put his affairs in order. He was not distressed and continued to be philosophical about his prognosis.

48. On 1 July the nurse accompanied the man to the oncology department. He was told that his cancer had spread to his liver and that without treatment he was likely to live approximately three months but with palliative treatment this might extend to 12 months. At this point, he did not want systemic chemotherapy but he was unsure whether to agree to palliative radiotherapy.

49. On 5 July he discussed his treatment in detail with the two nurses. He said that he did not want treatment. He asked his solicitor to start the process of release on compassionate grounds but was unsure whether he wanted to leave the

prison. He agreed that the prison family liaison officers could be informed of his diagnosis and that evening, two of them saw him and explained their role. He was happy to talk about his diagnosis. They told him their aim was to make things easier for him in relation to his family and friends. He explained that he had not been in contact with his family for many years and did not wish to do so but wanted to make contact with an old friend. They agreed to meet again the following week to discuss the process of contacting him as well as financial matters, his funeral and his next of kin. The clinical team leader also spoke to the man's wing manager to offer support for an application for early release on compassionate grounds.

50. A Governor as the senior prison manager in the prison's palliative care team, saw the man with the clinical team leader on 8 July. They discussed his planned care and the man emphasised that he wanted to remain on C wing for as long as possible where he knew the staff well and his friends were around him. He accepted that as he became increasingly ill he would need to transfer to the healthcare centre where his condition could be better monitored and his nursing needs met more effectively. He said he was grateful for the supportive regime that prison staff had put in place for him, ensuring his access to healthcare, an open door policy and easy access to meals at the servery or when necessary in his cell.

51. However, the man complained that, occasionally, night patrol staff ordered him not to press the cell call bell. The governor instructed the wing senior officer to ensure that the handover book recorded that the man had been told to press the call bell whenever he needed medical attention. The governor also offered other support such as appropriate food and new clothing as he was losing weight rapidly.

52. The doctor, the clinical team leader and the prison Macmillan nurse carried out a holistic assessment on 20 July and made adjustments to the man's pain relief. He asked for an inter-prison visit from a friend at HMP Acklington. The nurse advised that it was unlikely to be granted as such visits are normally only granted to family members. However, it was subsequently approved and took place on 28 July.

53. On 25 July, the man complained that he had been approached by other prisoners who asked for his medication in return for tobacco but he had refused. As a result, prison staff took a number of steps, including giving him a chair to use during association (when prisoners are allowed out of their cell to socialise) which would allow him to leave his cell. They also gave him a key to his cell so that he could keep his medication safe

54. Over the next few days, the man's pain levels increased and his medication for breakthrough pain was issued more frequently. Every day, staff offered him the opportunity to transfer to the healthcare centre which he consistently declined. On 4 August, after referral from the palliative care team the Head of Resettlement, began an application for consideration of early release on compassionate grounds or release on temporary licence (ROTL) at the end of his life.

55. Due to the nature of his offences, Northumbria Probation Trust did not support the application as the man had only completed a short period of his sentence and had no one in the community to care for him. Probation staff noted on the application form that there was no release plan, he had completed no work on his offending behaviour and that he was at medium risk of re-offending. In light of this objection, The head of resettlement did not submit the application to the Secretary of State for consideration. (In any case, the man subsequently decided that he wished to remain in prison with friends and sympathetic staff around him rather than leave and end his life in a community end of life facility.) The following day, he attended the oncology clinic with Macmillan The prison macmillon nurse where he agreed to radiotherapy and appointments were to be made for him to attend hospital for four sessions over four days.

56. On 11 August, the man declined to attend outside hospital to have a CT scan before receiving palliative radiotherapy as he did not feel well enough. Healthcare staff contacted the cancer centre to confirm the start of his series of radiotherapy appointments on 17 August but they said it was unlikely to take place because of the missed CT scan. The radiotherapy was postponed and the scan rescheduled

57. The following day, the man was admitted to the healthcare centre. He was still not fit enough to attend hospital for radiotherapy and an agreement was made to contact the cancer centre again the following week to reassess the position.

58. The man insisted that he wanted to remain at Durham for his care and that in the event of a collapse or severe deterioration he did not want staff to resuscitate him. Medical staff noted that he was fully alert and had the mental capacity to make that decision and made him aware that he could change his mind at any time if he so wished. A “Do Not Attempt to Resuscitate” form was completed to this effect and arrangements were made to ensure the form was handed over to all operational and nursing staff caring for him. Discussions took place with the pharmacist to confirm the availability of appropriate medication and specialist equipment such as syringe pumps.

59. During the next few days, the man appeared to be comfortable although he remained weak and tired. An urgent request for a hospital standard bed, pressure relief mattress and a static cushion was made from the Home Equipment Loan Service and was delivered on 15 August. He was provided with a kettle. The man still did not feel well enough to go to the cancer centre for a CT scan and this was kept under review.

60. As the man was having difficulty swallowing he was given soup daily. He was also given help with his personal care and there was an open door policy. Staff and other prisoners were said to be considerate of his needs.

61. Over the following week, the man settled and suffered little pain. On 23 August, he attended the hospital for a CT scan. His radiotherapy treatment then took place daily for the following four days, each session lasting for 15 minutes.

62. At around 4.30am on 29 August the man became confused and fell, hurting his ribs and grazing his knee. An X-ray revealed no injuries but he did not feel well enough the next day to attend the cancer centre for further palliative radiotherapy.

63. On 31 August, The prison macmillon nurse noted the man was very tired and clearly deteriorating. He was also less mobile and spending more time sleeping and reluctant to receive personal care. He remained pain free while at rest but had some discomfort when moving or coughing. He reported difficulty swallowing tablets and, after assessment by a doctor, a decision was made that he was stable enough to convert him from tablets to analgesic patches (Fentanyl). A pressure sore risk assessment was completed which identified a grade one pressure ulcer to his lower spine and an overlay mattress was ordered.

64. Staff discussed with the man the option of a Release on Temporary Licence (ROTL) to an outside hospital for end of life care but he preferred to remain at Durham. He confirmed his decision not to be resuscitated.

65. The multidisciplinary team met to be informed of the man's deterioration and to review his end of life plan. Relevant departments and individuals within Durham were given an update on his deterioration and arrangements made for friends and staff from the residential wings to visit him. His last radiotherapy session was cancelled as he was too unwell. Over the next few days intense nursing care was continued. He slept much of the time and took little food or fluid.

66. A doctor assessed the man after he had a fall and banged his head on 5 September. He appeared frail but had no significant injuries. The doctor noted he had breathing difficulties and was concerned to avoid pneumonia.

67. The CPN saw the man for a short while in his room on 6 September. She noted his speech was incoherent and rambling and his thinking disorganised. He had visual hallucinations but was not distressed. She noted in the care plan that there was a need to continue focussing on the man's comfort, to use clear and simple communication, alleviate his isolation and provide re-assurance. His medication was altered to liquid form because of his inability to swallow properly. From the following day, he received constant nursing care to make him comfortable. He continued to deteriorate rapidly.

68. In the early evening, the care team assessed that the man met the criteria to start the Integrated Care Pathway for end of life care. The multidisciplinary team conducted a review, anticipatory medication was prescribed and prison staff informed. A member of staff sat with the man and extra nursing staff were on duty that night to ensure that he was pain free and comfortable.

69. In the late morning of 8 September, various staff were informed that the man's death was expected and those who were close to him advised to visit him soon if they wished to do so. The family liaison officer also informed his next of kin.

The man died peacefully at 5.10pm, with two nurses at his bedside and was certified dead by the duty doctor, at 5:57pm.

70. Immediately after the man's death, the Durham death in custody contingency plan was activated. His nominated next of kin, was informed of his death by one of the family liaison officers, who kept in touch with him.

71. A post mortem examination was carried out by a doctor. She concluded that the cause of death was pulmonary abscess and pleurisy due to metastic small cell carcinoma of the right lung contributed to by diabetes mellitus

72. The prison chaplain conducted a memorial service for the man at HMP Durham on 15 September which many of his friends and prison staff attended. On Wednesday 28 September the chaplain conducted a funeral service at the local crematorium which was attended by the friend acting as the man's next of kin, friends, members of the prison chaplaincy, wing and nursing staff. HMP Durham met the costs of the funeral.

73. The family liaison officers delivered the man's ashes to his next of kin's home in Scotland. In accordance with his wishes, they also gave him the man's remaining property and money

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical care

74. On arrival at Durham, the prison healthcare team noted the man's medical history and were aware of his complex healthcare needs. The clinical reviewer concluded that clinical referrals and medical interventions both before and after his cancer diagnosis were appropriate, prompt and met the palliative care standards as well as the National Health Service Frameworks for diabetes and coronary heart disease. He had frequent secondary care and appointments at outside clinics were facilitated on most occasions. All exceptions were beyond the control of healthcare and prison staff.

75. The man's pain was continually assessed and, in the main, well controlled with drugs appropriate to the stage of cancer. When he had difficulty swallowing tablets for pain relief he was given liquid analgesics and, when that became difficult, analgesic patches were used. At the very end of his life, pain relief medication and equipment to administer it under the skin were available to support him. Appropriate food and dietary supplements were provided and, as his appetite reduced, a specialist dietary nurse assessed his needs and advised on his food and fluid intake. That advice was acted upon.

76. Staff carried out environmental assessments and obtained specialist equipment, ensuring the man was comfortable, pain free and his dignity preserved. Healthcare staff monitored his physical condition and regularly offered the opportunity to be admitted to the healthcare centre. His choice was to remain in his cell on C wing where he was supervised and managed effectively. This continued until the man decided it would be better for him to move to the healthcare centre.

77. The clinical reviewer concludes that the man's treatment was well coordinated and patient-centred. At the end of his life, healthcare staff provided 24 hour nursing cover at his bedside. The clinical reviewer commented that "this constitutes very good practice and meant that [he] did not die alone." We agree with that assessment.

Mental healthcare

78. At reception into Durham, the man's previous history was established and his mental health was addressed appropriately. The prison psychiatrist and CPN, were in close contact with him frequently throughout his time at Durham. The CPN, was surprised that psychological services were not fully involved in the Integrated Care Pathway multidisciplinary team who cared for the man as he approached death. However, the CPN's frequent and supportive interaction with the man throughout met the aim of delivering a responsive and well-rounded service to him. .

79. When the man was diagnosed with cancer and the frequency of his medical investigations increased considerably, the psychiatrist felt there was no need to continue seeing him and removed him from the patient list. The man still had

regular mental health reviews and was supported by the CPN who would have re-referred him if necessary. It is likely that the consistent input by psychiatric staff, despite no diagnosis of significant mental illness, helped him to understand and accept his diagnosis.

80. The man opted not be resuscitated if his heart or breathing stopped. The decision was discussed with him at length, documented and re-assessed as his illness progressed. A capacity assessment was completed to ensure that he had adequate understanding to make an informed decision and the clinical reviewer commented that thus was good practice.

Palliative care

81. It is evident that the man was subject to and benefitted greatly from HMP Durham's commitment to the Palliative Care Project and the more specific Integrated Care Pathway for End of Life Care. The care given was responsive to his needs and respectful of his wishes following the diagnosis of terminal cancer and until his death. All decisions were made with the knowledge and agreement of the man and were properly documented.

Pastoral care

82. The chaplain, family liaison team and his personal officer were closely involved with the man's care ensuring that, where possible, his wishes regarding the place and manner of his death and arrangements afterwards were carried out. They met regularly and he was involved in all decisions that affected him.

83. The family liaison team became involved with the man soon after his diagnosis and made excellent efforts on his behalf to ensure that he had the opportunity to communicate with those people significant in his life and to settle his affairs before his death. Despite no formal religious beliefs, he accepted the approach of the chaplain who supported him during the last months of his life and conducted his funeral. The Chapel was often put at the disposal of others to facilitate visits from doctors, both medical and mental health, solicitors and for an inter-prison visit to the man, as it was conveniently close to the man's cell when he became less mobile.

84. The man's personal officer, was instrumental in ensuring the man was supported and properly monitored on C wing. He also visited socially, and facilitated the attendance of prisoners from the wing after the man transferred to the healthcare sentence. We recognise that many other healthcare and prison staff and prisoners in countless ways took roles in supporting the man, ensuring his comfort, support and wellbeing during the last months of his life.

Compassionate release

85. A few days after his diagnosis in July 2011, the man asked his solicitor to begin the process for early release on compassionate grounds. One of the prison managers prepared an application the following month, however, the Probation Trust made it clear that they were opposed to his release and gave their

reasons. The man later decided that, in any case, he wished to remain in Durham until his death.

CONCLUSION

86. The man had several existing and serious medical conditions when he entered prison. They were monitored and reviewed regularly by both prison and NHS clinicians and were appropriately treated. Once he was diagnosed with cancer, his healthcare was responsive to his needs and wishes and was delivered sympathetically. He was also well supported by his friends, healthcare and prison staff. The clinical reviewer considered that the man received excellent care from primary and secondary care services in prison.

87. When his prognosis was confirmed, the man was managed under the Integrated Care Pathway for End of Life Care. As his condition worsened and he required greater input from healthcare staff, he was well looked after and given the option of admission to the healthcare centre at any time. Although he initially wished to be considered for early release from prison, he later changed his mind and asked to remain in Durham. A wide range of people gave assistance and facilitated every aspect of his advance care plan, including those after his death.

88. The man's care was well co-ordinated and centred on his needs. We are satisfied that it was of a very high standard and attention was paid to his social, spiritual and pastoral needs throughout. All who dealt with him, both prison and other professional staff treated him with humanity and dignity.