PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in December 2011 at a hospice, shortly after release from HMP Elmley

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of a man in December 2011 at a hospice. He had been in the custody of HMP Elmley. He was 65 years old and died from lung cancer. I offer my condolences to his family and friends. I regret that my report has been delayed.

The investigation was carried out by an investigator. The local Primary Care Trust appointed a clinical reviewer to conduct a clinical review of the standard of healthcare the man received at Elmley. HMP Elmley cooperated fully with the investigation. I apologise for the delay in issuing this report.

After his diagnosis, the man underwent chemotherapy and radiotherapy treatment and received appropriate support from prison healthcare and community palliative care nurses. He moved to a hospice five days before his death and was able to die with dignity. I am satisfied that he received good care at the prison throughout his illness which was at least equivalent to that which he might have expected in the community. However, it is regrettable that the handling of his application for compassionate release was not given sufficient priority, first at the prison and subsequently at National Offender Management Service headquarters, so that a decision was not made until minutes before his death.

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 **January 2013**

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SUMMARY

1. In February 2011, the man was convicted of a serious offence and sentenced to nine years and four months in prison. He returned to HMP Elmley where he had been remanded in custody since December 2010.

2. There were no concerns about his physical health until 3 March when he complained of a pain in his chest. He was referred for a chest x-ray, which showed that he had a mass in his left lung. Following a CT scan[1] and lung biopsy he was diagnosed with a squamous cell carcinoma[2] of the left lung. We are satisfied that the diagnosis of his illness was timely and he was informed appropriately and told of his treatment options.

3. The man underwent chemotherapy[3] and radiotherapy[4] treatment for his condition. Palliative care specialists at a local hospice were asked to visit and gave advice on pain relief and symptom control. The clinical reviewer considers that his care was comparable to that he could have expected in the community. He describes his pain relief as 'exemplary'. He did not have a formal end of life pathway and we therefore recommend that one is implemented for prisoners who have been diagnosed with a terminal illness.

4. The Head of Healthcare was advised by a community palliative care nurse on 7 December that the man's life expectancy could be in the region of two to three months. She asked the man's hospital consultant to provide a medical assessment to enable an application for early release on compassionate grounds to be submitted. However, the report said an accurate assessment of his life expectancy could not be made until he had undergone a CT scan in January 2012.

5. Because the Head of Healthcare was reluctant to delay the man's application, she arranged for him to be assessed by a doctor at the hospice on 20 December. He did not attend this appointment because the prison did not provide officers to escort him. The doctor agreed to see him on 29 December, but following a sudden deterioration in his health, he was moved to the hospice on 23 December. The same day he was visited by a prison doctor to undertake an assessment of his medical condition. An application was sent to the Public Protection Casework Section at the National Offender Management Service (NOMS) on the same day, but due to the Christmas holiday period it was not

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

[2] Squamous cell lung cancer is a form of non-small cell lung cancer. Squamous cell lung cancers usually begin in the bronchial tubes (large airways) in the central part of the lungs.

[3] Chemotherapy is a treatment for cancer where medicine is used to kill cancerous cells. It can be given in tablet form or as an injection into a vein.

[44]Radiotherapy, also known as radiation treatment, is the controlled use of high energy X-rays to treat many different types of cancer.

considered until 27 December. He was released on compassionate grounds three minutes before his death. We recommend that appropriate priority should be given to dealing with applications for compassionate release for terminally ill prisoners.

6. The man died in the hospice with his family at his bedside. Although he did not agree to any contact with his family until very shortly before his death, best practice would have been to have immediately appointed a family liaison officer. As it was, this took place the day after his death.

THE INVESTIGATION PROCESS

7. The investigation was undertaken by an investigator. She visited Elmley on 9 January 2012 and was given access to his prison records. She saw the healthcare unit and the unit where he lived during his time at the prison.

8. During this initial visit, the investigator met a member of the Independent Monitoring Board (IMB)[5] who raised no concerns about the man's treatment. She also met a respresentative from the Prisoner Officers Association (POA)[6] to explain the investigation process. Notices to staff and prisoners about the investigation were displayed at the prison.

9. The local Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a clinical review of the man's healthcare at Elmley.

10. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and to invite them to ask any questions or raise any issues for consideration. They did not raise any issues at that stage.

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

12. We apologise for the delay in issuing this report which was caused by workload pressures in this office and staff absences.

13. As part of the consultation process, the man's family received the draft report. They did not wish to provide any comments. The report was also sent in draft to the Prison Service. Their response to the recommendations is included.

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[5] Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.

[6] The POA represents uniformed prison grades.

HMP Elmley

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

Her Majesty's Inspectorate of Prisons

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

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

Independent Monitoring Board report

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

Previous deaths at Elmley

17. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 18 deaths at Elmley, of which ten were due to natural causes. The investigation into the man's death has raised similar issues to those identified in previous cases. These are related to the appointment of a family liaison officer when a prisoner is diagnosed with a terminal illness and that a formal end of life pathway should be implemented when a prisoner nears the end of their life.

ISSUES

The diagnosis of the man's terminal illness

18. The man was charged with a serious offence and remanded in custody to HMP Elmley on 20 December 2010. He was convicted on 28 February 2011 and sentenced to nine years and four months imprisonment.

19. On 20 December, he had a routine first reception health screen which did not identify any concerns. He declined the offer of smoking cessation advice. On 12 January, he was prescribed medicine after seeing the doctor with a cough. On 3 March, he complained of chest pain which became worse on inhalation and was referred for a chest X-ray.

20. The X-ray results were received the same day and showed that the man had a mass in his left lung. A prison doctor made an urgent referral for him to attend hospital on 9 March for further examination. A consultant chest physician told him that he needed a CT scan of his chest that day and a lung biopsy[7] to determine his condition. The biopsy took place on 29 March. He was also referred for a PET scan.[8]

21. The results of the CT scan and lung biopsy showed that the man was suffering from a squamous cell carcinoma of the left lung.

22. The clinical reviewer noted that he was referred to husing the 'two week rule'. Under this NHS clinical governance rule, all patients that are suspected of having cancer have to be seen in secondary care within two weeks. We are satisfied that his condition was appropriately and timely diagnosed.

Informing the man about his condition and treatment

23. The man was informed about his condition by the consultant chest physician and a Macmillan lung cancer nurse specialist on 5 April 2011. He was told that the results of the CT scan had confirmed the presence of a tumour in his left lung. He was also told that the biopsy results showed that he was suffering from a squamous cell carcinoma.

24. The nurse told him that that a lung multi disciplinary team (MDT) meeting had been held to determine the most appropriate form of treatment. He was told that the MDT decision was for him to be referred to a consultant medical oncologist for consideration of palliative chemotherapy and radiotherapy treatment.

25. Following his return to prison the man was seen by a nurse. He told the nurse that he was not entirely surprised by his diagnosis but did not wish to discuss it further at that time. He was made aware of the support available from healthcare and prison staff.

[7] A biopsy is the removal of a sample of tissue from the body for examination.
[8] A PET scan shows how the body tissues are working as well as what they look.

26. On 12 April, the man was seen by the oncologist and they had a long discussion about the diagnosis and its implications. The oncologist recommended that he should start chemotherapy treatment. He was told that he would receive his chemotherapy treatment intravenously[9] and in tablet form. He was shocked to hear that his life expectancy was approximately twelve months. The oncologist considered that he needed some time to come to terms with his diagnosis and arranged a further appointment for 26 April. At the same time he was referred to a hospice for support from the community palliative care team.

27. The man decided to proceed with chemotherapy treatment and, on 27 April, he was given a treatment schedule which detailed his chemotherapy appointments.

28. The clinical reviewer considers that the man was given information about his diagnosis and treatment in a "timely, constructive and considerate manner". We agree with this view.

The man's medical appointments and treatment

29. On 3 May, the man went to the Oncology Centre at the hospital for his pre-chemotherapy assessment. The purpose of this appointment was to provide him with information about how the treatment would be given, which would be through an intravenous drip, and any possible side effects.

30. He started his chemotherapy treatment on 5 May. Following his treatment a discharge summary was completed which detailed the chemotherapy medication he would receive from healthcare staff in Elmley. He received further chemotherapy treatments on 26 May, 16 June and 7 July. Arrangements were made for his pre-chemotherapy assessments to be carried out by telephone before these appointments. His medical record shows that the first pre-chemotherapy telephone assessment did not take place as planned on 2 June, as the telephone was not answered in the healthcare department. On 9 June, the healthcare appointments clerk spoke to the hospital to confirm which member of healthcare staff would host the review and the telephone number that should be called. The medical records show that a pre-chemotherapy telephone assessment took place as arranged on 23 June.

31. On 14 July, the man's temperature was recorded as raised at 37.9 degrees and the chemotherapy team at the hospital advised he should be taken there. He returned to Elmley on 16 July. Two days later he returned to hospital because his temperature was 38.4 degrees. He returned to the inpatients unit at Elmley on 20 July. His medical records show that during his chemotherapy treatment he was regularly reviewed by the oncologist.

32. On 6 September, the man underwent another CT scan to determine his suitability for radiotherapy treatment and the oncologist concluded that he should start a course of palliative radiotherapy. He received his first

[9] The term intravenous usually refers to giving medications or fluids through a needle or tube inserted into a vein.

radiotherapy treatment on 6 October and every weekday between 11 October and 26 October.

33. Following his radiotherapy treatment the man was reviewed by a consultant clinical oncologist at the hospital on 7 December. He arranged for him to undergo a further CT scan on 6 January 2012, with a follow-up appointment on 18 January.

34. The clinical reviewer has not raised any concerns regarding the man's medical appointments and treatment. He notes that following his outpatient appointments his treatment plans were outlined and hospital staff provided an information report to the healthcare department at Elmley which detailed his medication and follow-up care. This helped the prison provide appropriate medical care.

The man's pain relief and medication

35. The man's medical record shows that he was prescribed dexamethasone and metaclopramide by the oncologist to reduce the side effects associated with chemotherapy treatment, in particular nausea and vomiting. He took this medication daily throughout his chemotherapy treatment.

36. On 1 July, a prison doctor prescribed morphine to control the man's pain. His pain relief was regularly reviewed by the prison's palliative care nurse and a MacMillan palliative care nurse from the hospice. On 9 and 16 December, he was given oramorph because he was experiencing increased pain. His pain relief was reviewed on 21 December and he was also prescribed zomorph[10].

37. The clinical reviewer has noted that on the 23 December 2011 just a few days before he died, the man said he was not in pain. He considers that his pain management was "exemplary in part due to the role played by the hospice team".

Liaison with the man's family

38. The medical record shows that on 23 December an operational manager at Elmley asked the man for permission to contact his family to inform them that he was being moved to the hospice. He said he did not want the prison to let his family know.

39. The same day another operational manager visited him at the hospice. During this visit he changed his mind and the operational manager informed his family on 23 December.

40. After the man's death, a prison's family liaison officer (FLO) was appointed. The FLO log shows that he contacted the man's family and introduced himself as the prison FLO and offered his condolences. He explained that the prison would meet the costs of the funeral. The family said they were at his bedside

[10] Zomorph contains morphine sulphate, which is a type of medicine called an opioid painkiller.

when he died and they did not have any concerns about his treatment. The funeral took place on 11 January 2012, which the FLO attended.

41. Although the man did not agree to his family being contacted until a few days before his death, it is good practice for a family liaison officer to be appointed as soon as possible once a prisoner is seriously or terminally ill. In the event this took place the day after he died. In the circumstances, we do not make a recommendation

The man's location

42. While he was at Elmley the man lived in the healthcare inpatients department (IPD) because he was employed as the department's orderly. He remained in IPD until 23 December when he was moved to the hospice following a deterioration in his medical condition.

43. We agree with the clinical reviewer that he was moved to the hospice at the appropriate time and this allowed him the care he needed at the end of his life.

Compassionate release

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

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

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

46. On 7 December, the Head of Healthcare at Elmley was advised by the Macmillan nurse that the man's life expectancy could be in the region of two to three months. She asked a doctor to provide a prognosis report. The report was received on 19 December and it said that he would be unable to provide an accurate assessment of the man's life expectancy until he had undergone a CT scan in January 2012.

47. In light of the Macmillan nurse's opinion, the Head of Healthcare was reluctant to delay the man's application for early release on compassionate grounds. She contacted a doctor at the hospice on 15 December and asked if he would see him to provide an accurate report on his prognosis to enable his application for early release on compassionate grounds to proceed. The appointment was arranged for 20 December and the doctor agreed to provide his report on the same day. The man did not attend the appointment as the prison did have not enough staff to provide an escort. The Head of Healthcare only became aware of this when the doctor telephoned and asked why he had not attended. The doctor then agreed to see him on 29 December.

48. On 23 December, the man was moved to the following a deterioration in his condition. The same day he was visited by a prison doctor to undertake an assessment of his medical condition. The doctor was asked to assess whether he would be capable of committing further offences if he was released from prison. She noted that his physical condition had severely deteriorated and he was in discomfort despite pain management.

49. The Governor of Elmley completed his assessment on the same day, Friday 23 December. He wrote that the man's behaviour was good and a prison risk predictor had indicated a low risk of re-offending. The Governor noted that he was receiving palliative care at a hospice and the medical report suggested that he was likely to die soon. He wrote that his prognosis was difficult to determine.

50. An application for early release on compassionate grounds has to be approved by the Public Protection Casework Section (PPCS), a casework unit within the National Offender Management Service (NOMS). The man's application was sent to PPCS at 3.42pm on 23 December but, as it was the Christmas holiday period, his application was not considered until 27 December.

51. At approximately 9.39 an officer received a telephone call from the hospice doctor to say that the man was unconscious and likely to die that or the following day. He told the investigator that he emailed and telephoned several staff at PPCS to seek an urgent update on the man's application for compassionate release but did not receive a response. He managed to contact the Head of the Public Protection and Mental Health Group, who requested further information about his medical condition from the hospice. This information was provided by the doctor at approximately 10.14am and forwarded to him at 10.17. The man was released on compassionate grounds at 10.25 am. The time of his death is recorded as 10.28am. We are surprised in an operational service there does not appear to have been cover to deal with such an application over the holiday period.

52. The Head of Healthcare took the appropriate steps to enable the man's application for early release on compassionate grounds to be considered. It is most unfortunate that he was not taken to his appointment with the hospice doctor on 20 December because there were no prison officers available to escort him. He had been released on a special purpose licence, unrestrained and accompanied by one prison officer, when he attended hospital for his radiotherapy treatments. There is no reason why he could not have attended

his appointment with the doctor under the same conditions. The lack of available prison officers to escort him and the holiday period meant that the application for early release on compassionate grounds was unacceptably delayed.

The Governor and the Head of the Public Protection Casework Unit at NOMS headquarters should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that decisions are not unnecessarily delayed.

53. Prisoners who have been diagnosed with a terminal illness can also be considered for release on temporary licence (ROTL). Prison Service Order (PSO) 6300 sets out the policies and required actions that the Prison Service must undertake when considering an application for release on temporary licence (ROTL). Any release on temporary licence will only take place once the prisoner has satisfied a stringent risk assessment carried out by a designated ROTL Board at the prison. Prison Governors have an overriding duty, when considering any release, to ensure that both public safety and public confidence in the system are maintained. There is no automatic entitlement for release on temporary licence to be granted.

54. The man was first given ROTL on 28 September while he was having radiotherapy treatment. The licence stated that he would be released on a special purpose licence[11] on compassionate grounds to undergo treatment at hospital. He was unrestrained and accompanied by one prison officer. The records show that he was granted a further release on temporary licence on 7 December when he attended an appointment with a doctor.

55. On 23 December, the man was released on temporary licence to the hospice and accompanied by a prison officer who was not in uniform. We consider that the decision to release him on temporary licence to undergo radiotherapy treatment and attend hospital appointments was appropriate.

Palliative care plans

56. On 27 April 2011, the man was seen by the prison's palliative care nurse and a Macmillan nurse to complete the referral to the hospice's palliative care service. His diagnosis and treatment were discussed and advice was given regarding his diet. The Macmillan nurse advised that he should have a daily nutritional drink, increase his milk intake to six cartons a day, eat a sandwich in the evening and receive a high calorie diet. His medication was also reviewed. The Macmillan nurse prescribed medication for constipation and pain that he was experiencing in his left shoulder.

57. The palliative care nurse spoke to him on 25 May. During this meeting he said he had not received any of his dietary extras. She noted in the medical records that she had spoken to a Senior Officer, a prison healthcare officer, to ensure

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[11] A special purpose licence might be granted for prisoners to attend medical out-patient appointments, or in patient requirements.

that he received his dietary extras as arranged. During a further meeting with the Macmillan nurse on 2 June, he confirmed that he was now receiving them.

58. The medical records show that he was seen monthly by the palliative care nurses between August and December. On each occasion, he was given the opportunity to discuss any issues or concerns he might have.

59. A review of the man's mental health first took place on 29 September when he was seen by a prison mental health nurse. The nurse did not note any concerns. He was regularly reviewed by a nurse as part of his IPD core care plan.

60. The man's resuscitation status was first reviewed on 12 December as part of his care plan. He said he wished to be resuscitated if his heart stopped. A note in the medical record on 15 December said that his resuscitation status would be reviewed if there was a deterioration in his health. This was to ensure that his wishes were recorded with the objective of maintaining privacy and dignity.

61. He received support on a regular basis from the palliative care team. Having reviewed a full set of his medical records we are satisfied that his care was appropriately co-ordinated between the community palliative care team and the healthcare staff at Elmley using IPD core care plan. However, a formal palliative care and end-of- life pathway, was not used, although these have been developed at Elmley. The benefits of an end of life pathway include helping carers to plan the delivery of care and helping patients make choices about how they are cared for towards the end of their lives. While many of the matters covered by an end of life pathway were included in his IPD care plan, and we make no criticism of his care, best practice would have been to use a formal documented pathway to help ensure that no matters were overlooked.

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

62. In the clinical reviewer's opinion the man's care was comparable to the care he would have expected to receive in the community. We agree.

Restraints, security and bedwatch

63. When the man was taken to hospital on 26 May to start his chemotherapy treatment he was escorted by two members of prison staff and handcuffed to one of them. The prison escort record (PER) for that day states that his handcuffs were removed when he was undergoing treatment. The same applied during subsequent chemotherapy treatments. The prison has been unable to provide copies of the full risk assessments, but he was fully mobile at this time. Without the risk assessments it is not possible to judge whether his state of health was properly considered at the time, but subsequent decisions by Elmley about the level of security needed were dealt with appropriately. He was released on a special purpose licence when he underwent radiotherapy treatments. He was accompanied by one prison officer and was unrestrained.

CONCLUSION

64. The man's medical care involved hospital specialists as well as prison doctors, nurses and a community palliative care team. He was kept fully informed about his diagnosis and received appropriate treatment. His condition was well managed using an in patients department core care plan, but a formal end of life pathway was not implemented.

65. Following a deterioration in his medical condition the application process for early release on compassionate grounds was started. His application was delayed in part because he missed an appointment with a doctor due to a shortage of escort staff. He moved to a hospice on 23 December and his application was then sent to PPCS on 23 December. This was further delayed by the Christmas holiday period and a decision to allow compassionate release was made just minutes before he died.

RECOMMENDATIONS

1. The Governor and the Head of the Public Protection Casework Unit at NOMS headquarters should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that decisions are not unnecessarily delayed.

   Accepted:

   HMP Elmley response – The Governor will ensure (on the basis of the information being made available) that applications for compassionate release are completed in a timely manner and that liaison with Public Protection Unit is maintained so as to inform upon a prompt decision.

   PPCU response – This recommendation is accepted subject to the criteria for ERCG being met and all the necessary information being available.

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

   Accepted – The end of life policy will be reviewed, published and implemented (by Dec 2012). Our policy will reflect the guidance contained in the Liverpool Care Pathway. All staff will be trained to ensure a comprehensive knowledge base of the policy and to improve the provision of care for all adults at the end of life.