PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in June 2012 at a hospice while in the custody of HMP Dorchester

Our Vision

*‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man. He died of stomach cancer in a hospice in June 2012 while in the custody of HMP Dorchester. He was 52 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator, with the full cooperation of HMP Dorchester. The local PCT appointed a clinical reviewer to conduct a review of the man's clinical care.

The man was remanded in custody in January 2012, and was subsequently sentenced to seven years imprisonment in April, for an offence of arson, the victim being his estranged wife. He spent all his time in custody at Dorchester.

The man had no known significant physical medical conditions when he first arrived in custody, but was diagnosed with terminal cancer with a very short life expectancy, in May 2012. Following admission to hospital, he was transferred to a hospice on 14 June, and eventually released on temporary licence. He died several days later with his family at his bedside.

The man received a high standard of care from prison and healthcare staff, described by the clinical reviewer as exemplary. He and his family were treated with sensitivity and compassion throughout. I conclude that he received care equivalent to that he might have expected in the community and commend staff at Dorchester for the care they provided.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2012**

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SUMMARY

1. The man was remanded on 23 January 2012, and received a seven year sentence in April. He had no known physical health problems when he first arrived. He was considered at risk of self-harm for the duration of his time at Dorchester and measures were in place to support him.

2. When the man started to lose weight, he told staff that he was not eating because of anxiety and his dislike of prison food. The results of blood tests in May were abnormal, so he was referred for further assessment at hospital. Following diagnostic tests on 16 May, it was discovered that he had widespread cancer. He was informed of the diagnosis the next day by the prison doctor and readmitted to hospital for further assessment.

3. When the man was admitted to hospital on 25 May, he was told the prognosis was very poor and he declined palliative chemotherapy, although had blood transfusions for symptomatic relief. A family liaison officer was appointed and introduced himself to several members of his family. Following a multi-disciplinary team meeting at the hospital on 13 June, it was agreed in consultation with him, that he would be transferred to a hospice. He moved to a hospice the next day.

4. An application for early release on compassionate grounds (ERCG) was submitted following diagnosis, but was not processed before his death. He was released on temporary licence, although he was accompanied by one prison officer but was not subject to restraints while at the hospice. His family had unrestricted visits at the hospice.

5. One afternoon in June, the man's estranged wife was permitted to visit. Following this visit his health declined and he was pronounced dead that evening with his family at his bedside.

6. The clinical reviewer does not make any recommendations. We agree with his conclusion that the man's treatment before and after diagnosis was appropriate and equal to that he could have expected in the community.

THE INVESTIGATION PROCESS

7. The investigator visited Dorchester on 26 June, when she was given the man's documentation. She met the liaison officer, the Lead Nurse, a member of the Independent Monitoring Board (IMB), a safer custody representative and spoke to the prisoner disability representative. (IMBs consist 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.) At the end of the visit, she met the deputy governor.

8. Notices about the investigation were posted in the prison asking staff and prisoners who had information relevant to the investigation to contact the investigator. No one came forward.

9. The investigator returned to Dorchester on 26 July with her colleague to interview five members of staff and one prisoner. She met the Governor immediately after the interviews to give preliminary feedback, which was confirmed in writing on 30 July.

10. The local PCT commissioned a clinical reviewer to review the man's clinical care. He received copies of all relevant medical records to assist the clinical review, which was received on 30 August.

11. HM Coroner for Dorset was informed of the investigation. A copy of the investigation report will be sent to the Coroner.

12. One of the Ombudsman's family liaison officers contacted the man's daughter on 13 July, to inform his family about the investigation and to invite them to ask questions about his care while he was at Dorchester. His family did not have any specific questions.

13. 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. As part of the consultation period his family received a copy of the draft report; they did not raise any issues

HMP DORCHESTER

14. HMP Dorchester is a small local prison serving the courts of Dorset and the surrounding area and holds up to 271 male prisoners.

15. Healthcare services are provided by a Foundation Trust. The healthcare unit operates like a community general practice with GP services being available daily and out of hours provision from the Trust. The inpatient unit was closed in February 2012.

HM Inspectorate of Prisons (HMIP)

16. HM Inspectorate of Prisons carried out an announced inspection in March and April 2009. The report of a recent inspection has yet to be published. In 2009, inspectors noted that the prison was commendably safe, and that prisoner staff relationships were excellent. The inspection team observed prisoners being treated professionally and with respect in the healthcare centre and despite being rarely used; palliative care was supported with the cooperation of services in the community.

Independent Monitoring Board (IMB)

17. In the 2010/11 annual report for Dorchester, the IMB reported that, despite budget restraints and extensive building works, all staff remained professional and effective. Although the IMB had received an increase in healthcare complaints there were no discernible trends. The IMB noted that the health care unit worked well and there were new clinical rooms on the wings. A health promotion group had been set up and was achieving good results and there were designated link nurses for a range of conditions.

Previous deaths at Dorchester

18. There was one death at Dorchester in the year before the man died, which was due to natural causes. There were no direct similarities between this death and that of his.

ISSUES

19. On 23 January 2012, the man appeared at Magistrates' Court, charged with arson with intent to endanger life, which involved an attack against his estranged wife. He was remanded in custody at HMP Dorchester. Following his conviction on 2 April, he was sentenced to seven years imprisonment at Crown Court on 30 April.

20. He did not disclose any chronic or acute medical conditions and physically appeared physically fit and well on his reception at Dorchester. He weighed 71 kilograms (kg). He was assessed as suffering from severe depression and was assessed as at risk of suicide and self-harm and placed on monitoring procedures (ACCT - Assessment, Care in Custody and Teamwork procedures which are the principal tools for assessing, monitoring and managing any prisoner thought to present a risk of self-harm or suicide). He was monitored under the ACCT procedures for most of his time at Dorchester.

The diagnosis of the man's terminal illness

21. On 20 and 23 April during routine mental health reviews, the man told a mental health nurse that his antidepressant medication was upsetting his stomach. This was the first time he mentioned problems with his stomach, and the nurse referred him to the prison doctor for review.

22. A prison doctor examined him on 27 April. He told her that he was not eating as he could not bear the smell of the food and it looked awful. His abdomen was described by her as "soft, non tender" but he declined medication to improve his appetite. She requested blood tests and recorded his weight as 64.7kg. These blood tests were abnormal, but not significantly, so were to be repeated a month later.

23. Following sentencing on 30 April, the man was reviewed by a nurse from the mental health in-reach team on 1 May. She recorded that he looked pale and gaunt and he told her that he had lost weight as he was not eating, due to being very depressed. She started a food and fluid chart to record his intake, and planned that he should be weighed and have his blood pressure taken weekly. His antidepressant medication was increased.

24. On 9 May, he weighed 63.1kg. His blood pressure was normal at 115/86 but his pulse rate was high, at 108 beats per minute (bpm - normal range is between 60 – 80 bpm). The mental health nurse referred him to the prison doctor.

25. The doctor examined him the next day, 10 May. She recorded that his symptoms might have been a result of his depression, but that there was a potential underlying physical cause for his weight loss and referred him for a chest X-ray and an abdominal ultrasound. She prescribed Fortisip high energy drinks.

26. The doctor examined him on 16 May before his hospital appointment for his ultrasound and chest X-ray. He said that, before he came into prison, he had felt tired and full, struggled to finish his meals and would occasionally vomit. She alerted the registrar at the hospital that the referral should be treated urgently (for those suspected of having cancer).

27. The man went to hospital immediately after his consultation with the doctor and had an abdominal ultrasound scan and chest X-ray. These diagnostic tests showed that he had an enlarged liver and probable disseminated metastatic disease (widespread cancer). The radiology staff did not tell him his scan results, but the prison were contacted and the on-call prison doctor was notified. Healthcare staff were told to monitor him overnight and make him an appointment with the doctor the next day.

28. The clinical reviewer notes:

> "Were it not for the alertness of his [the man's] doctors this [depression] might have confused the diagnosis for some time … Although his symptoms at the time could all be put down to his depression [the prison doctor] reacted appropriately, examining him fully and arranging blood tests. These were inconclusive and rightly the doctor arranged for them to be repeated a month later, as well as keeping him under review … He was referred to specialist secondary health service soon after he first mentioned his symptoms and the referral was made within the two week rule".

29. In light of the clinical reviewer's comments, we conclude that the diagnosis of the man's terminal illness was timely and appropriately handled.

Informing the man about his condition and treatment

30. The prison doctor told the man on 17 May that the scan showed he had widespread cancer and that he needed to be assessed by a specialist for a full diagnosis. He gave permission for prison staff to be told of his condition. The veterans' liaison officer (providing support for prisoners who have served in the armed forces) joined the consultation and was informed of the outcome of the test results. The man did not want to inform his family at that point, because he wanted to wait until he had more definite information.

31. He was admitted to hospital the same day. He underwent a biopsy the next day which revealed that he had stomach cancer which had spread. He was discharged back to Dorchester on 21 May. He was given an appointment for an oesophago-gastro-duodenoscopy (OGD – a procedure using an endoscope that looks at the stomach to aid diagnosis) as an outpatient on 22 May. He returned to hospital for the results on 25 May, was told that the prognosis was very poor and was referred to an oncologist (a specialist cancer doctor).

32. The oncologist saw the man on 29 May and told him that his prognosis was very poor. His life expectancy was unlikely to be more than six months. He

declined palliative chemotherapy and chose to have symptomatic relief only (blood transfusions and pain relief). The prison doctor contacted the palliative care team at the hospital and the hospice for ongoing advice regarding his care and management.

33. Following his return to Dorchester, the prison doctor had a lengthy consultation with him and explained that, due to his terminal illness, resuscitation might not be appropriate. He understood and signed a Do Not Attempt Resuscitation (DNAR) form on 1 June, endorsed by the doctor.

34. Healthcare staff at Dorchester ensured that the man was fully informed at all times about his condition, from diagnosis to palliative care. He was supported by mental health staff to come to terms with his prognosis, as well as being provided with support by prison staff and his friends. The clinical reviewer writes:

> "Considerable care seems to have been taken at each stage to ensure he [the man] was left fully in the picture as to what was happening and why."

35. We are satisfied that the man was appropriately informed about his condition and prognosis.

The man's medical appointments and treatment

Appointments

36. The man was regularly reviewed at Dorchester by healthcare staff and no hospital appointments were cancelled. We were told that Dorchester has a policy to ensure that patients with a serious or terminal illness do not have appointments cancelled.

Treatment

37. Following the consultation on 25 May, a consultant haematologist (specialist in blood conditions) arranged for the man to be admitted for a blood transfusion as he was anaemic (lack of red blood cells resulting in low energy). Referral to the oncologist was made to explore if there were any viable cancer treatment options.

38. The man had a number of additional blood transfusions which increased his blood count, giving him more energy. The lasting effect of the blood transfusions diminished and, on 20 June, he was given his last transfusion.

39. His treatment options were limited to managing his symptoms, rather than curing the underlying illness. We agree with the clinical reviewer that his treatment was appropriate to his condition.

The man's pain relief and medication

40. The man was prescribed all the medications as directed by the hospital consultant and palliative care team. Healthcare staff regularly reviewed the palliative care plan and he was made as comfortable as possible. When considering his pain relief and medication, the clinical reviewer says:

> "Fortunately his [the man's] pain control in prison seems to have been adequate using drugs orally, and there do not seem to have been any intrusive security issues about him having morphine available appropriately."

41. In light of the clinical reviewer's comments, we conclude that the management of the man's medication and pain relief was appropriate to meet the needs of his condition.

Palliative care

42. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. It helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. The man did not have a formal end of life care plan, as he was transferred to hospital before one was needed, and then he went directly to the hospice. Good measures were put in place to ensure that his needs were regularly reviewed while he was at Dorchester and adjustments were made to ensure his care needs were met.

43. His care was reviewed daily by healthcare staff, which was recorded in the electronic medical notes. Specialist palliative care nurses continued to support healthcare staff at Dorchester and the prison doctor described communication with the hospital staff as good. Dorchester authorised oxygen to be kept on the wing to ensure that he was able to have easy access a times when he became breathless.

44. He was given a wireless door bell so he could alert staff if he could not reach the cell bell. The kitchen accommodated his food requirements. He was allowed to wear his own clothes and the veterans' liaison officer arranged for him to have his violin (which he played proficiently). At his request, he was taken around the periphery of the prison in a wheelchair for fresh air.

45. Dorchester held regular multi-disciplinary meetings to discuss the man's ongoing and changing needs. In addition to his physical care, his emotional and spiritual needs were also well considered, evidenced by the number of daily interactions with healthcare staff and staff's facilitation of contact with his family and the prison's veterans' liaison officer. Further, he was assigned a prisoner 'buddy' who assisted him by cleaning his cell and bringing him his meals. In his clinical review, the reviewer comments:

> "Considerable effort was made to ensure the man was looked after well in prison. Care was taken to see that he had a cell on the ground floor, a wheelchair was rented for him, his brother was allowed to visit and take photographs and his cell was made as comfortable as possible."

46. The clinical reviewer goes on:

> "There was clearly a very close relationship between staff and family who, more than once, expressed their gratitude for the quality of his [the man's] care. There appears to have been a close three way relationship between patient, family and staff."

47. We conclude that officers and healthcare staff provided a high standard of care with attention to both the man's physical and emotional needs.

The man's location

48. As soon as he was diagnosed with a terminal illness, the prison doctor discussed the man's care with the oncologist, and a referral was made to a hospice on 31 May. He was keen to return home to his family, but wanted to be transferred to a hospice if this was not possible.

49. Following his diagnosis, the man was moved to a cell on the healthcare wing on 22 May, but was moved back to his wing on 24 May, to ensure that he did not become isolated and was able to benefit from the support of his friends. The prison contacted the national population management unit to make enquiries as to the availability of a more suitable prison that could offer hospice facilities, but was told that there were no such facilities. It was decided that the care he was receiving at Dorchester was appropriate, as a referral to a local hospice had already been made.

50. On 13 June, a multi-disciplinary team meeting was held at hospital, attended by a senior palliative care nurse from the hospice, a social worker and chaplain from the hospital, as well as healthcare staff from Dorchester. During this meeting it was agreed that, due to the man's deteriorating health and the increase in his social care needs, he would be transferred to the hospice the next day. He and his family were told of the decision.

51. The clinical reviewer notes:

> "The man was able to stay in his cell, or one in the Health Centre, until his condition dictated otherwise…he [the man] deteriorated much faster than had been anticipated. However he was moved appropriately to the local hospice when the need arose."

52. We conclude that the man was located appropriately. He was very well supported by staff and prisoners while at Dorchester, which continued following his transfer to the hospice.

Compassionate release

53. All prisoners who have not reached their automatic release date, conditional release date or parole eligibility date may apply for early release on compassionate grounds (ERCG) for medical reasons. In order to be released on compassionate grounds, a prisoner must have a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

54. On 28 May, the man was told that he had no more than six months left to live. The same day, an application for ERCG was started and sent to the headquarters of the National Offender Management Service. To support an application, a release plan should be completed by probation and include a suitable release address, where any ongoing risks can be managed. He provided his brother's address in Loughborough and said that his daughter would be his main carer. The probation report was requested and enquiries about the suitability of the release plan began (including contact with another probation area, contact with the victim and a formal meeting with the police to consider how any risk would be managed should he be granted ERCG). While these issues were being considered, his family changed their mind about their ability to care for him and requested that release to the hospice was considered instead. The ERCG application was ongoing at the time of his death.

55. The man was considered for release on temporary licence (ROTL - in certain circumstances, a prisoner may be allowed to leave prison on a temporary licence). Risk assessments were completed and a report was obtained from probation, who supported the application, as long as an officer was present at the hospice (in civilian clothing) and he did not have contact with the victim of the offence (his wife). All reports were submitted by 15 June. The same day the Governor approved the ROTL licence, with the additional conditions outlined by probation. He was released on special purpose licence. An accompanying officer provided support for him when his family were not present.

56. In conclusion, there was a timely application for ERCG after the man's diagnosis. However, such was the speed of his decline a decision had not been made before he died. He was released on temporary licence, with consideration given to the needs of his victim, while maintaining dignity and support for him and his family.

Liaison with the man's family

Visits

57. The man was admitted to hospital on 17 May, when he was given his prognosis. The prison allowed him to use the prison escort mobile telephone to contact his family and tell them the news. His family were given unrestricted visiting access while he was in hospital.

58. Following his return to Dorchester, arrangements were made for the man's family to visit him in a quiet room on the healthcare wing, and they were allowed to visit the wing where he lived, on any authorised visiting day. After he was transferred to the hospice, his family again had unrestricted visits, and the accompanying prison officer kept a discreet distance to provide the family with privacy.

59. On 21 June, the man's family asked his estranged wife to visit him before he died. She asked the prison for permission to visit her husband. The duty governor considered the conditions of his licence and saw that there was a Restraining Order preventing him from contacting her. In interview, the duty governor explained that she did not think she was able to impose any restrictions on his wife attending the hospice and did not consider it was the prison's place to grant permission or otherwise. She asked another senior officer to attend the hospice in case there were any problems. The visit lasted a short while and he briefly regained consciousness. Their son and daughter were present. His wife left the hospice immediately after her visit. We consider that Dorchester managed this difficult situation appropriately.

60. Dorchester maintained regular contact with the man's family, advising and assisting them as best they could. They were told when he had been re-admitted to hospital and, with his consent, kept them updated regarding his condition. His family were with him when he died.

Family Liaison Officer

61. A Senior Officer (SO) was appointed as the family liaison officer on 20 May. He undertook a number of escort duties while the man was in hospital, which meant that he was more accessible for the family. After the man died, funeral expenses were offered and accepted, and all property was returned to the family. We consider family liaison was well managed.

Restraints, security and bed watch

62. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances. The risk assessment should consider the risk of escape and the risk to the public, also taking into account factors such as the prisoner's health and mobility.

63. On 16 May, when the man was taken to hospital, he was subject to standard cuffing restraints (single cuffs or two metre long escort chain with a cuff at either end) and escorted by two prison officers. He was still mobile and was assessed as high risk of harm to a known adult and low risk of harm in all other aspects

64. In reaching the judgement on the level of restraint used, Dorchester properly considered the risk posed by the man to the public, his risk of escape and his

physical condition. The risk assessment was reviewed each separate time he was transferred to outside hospital. On 7 June, as a result of a decline in his physical health and mobility, the deputy governor gave authority that restraints did not need to be applied although he was to be escorted by two officers. Restraints were never re-applied.

65. On each occasion the man was escorted outside the prison, the risk assessment was reviewed and medical opinion was sought. We are satisfied that, while it was not always fully recorded on each escort active risk assessment, appropriate account was taken of his health and physical condition and the impact this had on his actual risk while outside of the prison.

CONCLUSION

66. During his time at Dorchester, the man had well-documented and regular interactions with doctors and other healthcare staff. There was good liaison between healthcare staff and hospital specialists to ensure that he received appropriate treatment and medication following his diagnosis, and this was at least equivalent to that available in the community.

67. The care given to him by prison and healthcare staff was of a high standard, commended by the clinical reviewer. His family were able to spend unrestricted time with him during his final days at the hospice and were with him when he died. The clinical reviewer concludes that the care he received:

> "…was certainly on par with what he could have hoped for outside and will have exceeded the care available in some practices. All concerned should be congratulated."