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 at hospital in August 2012, while in the custody of HMP Channings Wood

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, a prisoner at HMP Channings Wood who died at hospital in August 2012. He was 48 years old. He had been suffering from cancer of the oesophagus. I offer my condolences to his family and friends.

A review of the man's clinical care in prison was conducted. Channings Wood cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man was diagnosed with terminal cancer towards the end of 2010, for which he was given palliative treatment. When he first reported his symptoms, there was a delay in referring him to a specialist under the NHS guidelines for suspected cancer and I am concerned that healthcare staff did not recognise and act on the severe symptoms of his illness. There was also a delay in informing him of his diagnosis. After his diagnosis, staff at Channings Wood provided a good standard of care and support, underpinned by a comprehensive care plan but there was a succession of missed hospital appointments in spite of his oncologist reminding prison healthcare staff of their importance.

Some other learning points were also identified by the investigation: the possibility of early release on compassionate grounds was not kept under review and the use of restraints when the man went to hospital was not always justified by appropriate risk assessments. Although a family liaison officer was not appointed as soon as his terminal illness was diagnosed, which would have been best practice, I note that the man's mother commended the kindness she received from the prison.

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 2013**

CONTENTS

SUMMARY

1. The man was convicted of sexual offences on 20 May 2008 and received an indeterminate sentence for public protection. He had no longstanding medical conditions when he first went into prison.

2. On 4 November 2010, after reporting symptoms of weight loss, abdominal pain and difficulty swallowing, the man was initially treated with antacid medication. The doctor planned to send him for an internal examination of his oesophagus, stomach and duodenum by camera if the symptoms persisted. Three weeks later, on 25 November, another prison doctor referred him urgently to hospital with suspected cancer. Test results indicating throat cancer were received by healthcare staff at the prison on 12 December, but he was not informed until 21 December. It is unclear from records why there was such a delay. The clinical reviewer considers that the seriousness of his symptoms should have been recognised when he first reported feeling unwell in early November.

3. After the man's diagnosis, prison healthcare staff produced a care and support plan, which a multidisciplinary team reviewed at appropriate intervals. As his cancer was inoperable, he received palliative treatment only. He missed several hospital appointments for reasons that can be attributed to the prison. Risk assessments carried out for outpatient hospital visits and emergency hospital admissions resulted in the use of restraints for hospital visits but there was too little information in the assessments to justify the decisions.

4. Eating and swallowing became more difficult for the man, so he was fitted with a stent to hold open his oesophagus and given a soft diet with liquid supplements. He signed an advance directive (indicating he did not want to be resuscitated in the event of a cardiac or respiratory arrest) which he later rescinded, after his condition stabilised. He applied for compassionate release but this was refused in August 2011 because his condition had stabilised. The possibility of early release was not kept under review and no further applications were made as his condition worsened.

5. On 13 August 2012, the man was found in his cell coughing up blood and in severe pain. He was taken to hospital by emergency ambulance, without restraints, where he later died.

6. We make recommendations about the need to promptly refer for suspected cancer, immediately inform a prisoner of his diagnosis, pursue early release on compassionate grounds, facilitate hospital appointments and undertake appropriate risk assessments for the use of restraints.

THE INVESTIGATION PROCESS

7. Notices were issued announcing the investigation to staff and prisoners, inviting anyone who had relevant information relating to the man's death to contact the investigator. Three prisoners came forward as a result and spoke to the investigator.

8. Another investigator began the initial elements of the investigation on behalf of the first investigator, while investigating another death at the prison. He visited the unit where the man had lived and spoke to two officers. He also visited the healthcare centre, and spoke to the deputy healthcare manager. He met the prison's family liaison officer and the deputy governor.

9. The investigator visited Channings Wood on 30 October and 20 November, to conduct interviews.

10. A clinical reviewer carried out a clinical review of the man's time in custody.

11. One of the Ombudsman's family liaison officers spoke to the man's mother to explain the investigation process. She said that her son had spoken highly of the care he had received in prison and that she had found the prison chaplain very kind. His mother had no specific matters for the investigation to consider.

12. The investigation 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 appropriate palliative care provided.

13. We are sorry for the delay in issuing this report, which was caused by staffing changes during the course of the investigation.

HMP CHANNINGS WOOD

14. HMP Channings Wood is a category C training prison near Newton Abbott in Devon. It holds over 700 convicted adult prisoners, a large proportion of whom are considered vulnerable, mainly due to the nature of their offences.

15. Health services at Channings Wood, at the time the man was there, were commissioned by NHS Devon and provided by the Devon Partnership Trust. Since 1 April 2013, health services have been provided by Dorset NHS University Trust. There is no inpatient unit. Nurses are on duty every day. An out of hours GP service is provided by Devon Doctors.

HM Inspectorate of Prisons

16. The last inspection of Channings Wood was in September 2012. The Inspectorate report noted that the prison continued to perform reasonably and the provision of healthcare was satisfactory, but services had been disrupted by the absence of a healthcare manager and staff vacancies. Access to nurses and a GP was judged to be reasonable.

Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life, to help ensure that prisoners are treated fairly and decently. The Board's annual report for the year to 31 August 2012, noted that there has been deterioration in the overall performance of healthcare. The frequent use of agency nurses had led to difficulties when emergency cover was required. The IMB concluded:

> "The unfamiliarity of temporary medical and nursing staff with both prisoners and prison systems has resulted, in our view, in a failure of prisoners' rights (i.e. their right to receive a standard of medical care consummate with that received by the wider community). Additionally, it is the belief of the Board that long term medical care, particularly of prisoners presenting with chronic conditions, can slip under the radar as a result of the above problems."

Previous deaths at HMP Channings Wood

18. The man was one of eight prisoners to die at Channings Wood since January 2012. There are no direct similarities in the circumstances of these deaths. However, in previous cases we have been critical of the unnecessary use of restraints in hospital. We are pleased to note that he was not restrained when he was taken to hospital just before his death.

ISSUES

The diagnosis of the man's terminal illness

19. The man was convicted of sexual offences on 20 May 2008 at Crown Court. He was sentenced to an indeterminate sentence for public protection, with a minimum time to serve of eight and a half months. He was taken to HMP Bristol and transferred to HMP Channings Wood on 9 February 2009. He was fit and healthy when he arrived at Channings Wood with no longstanding medical conditions.

20. On 4 November 2010, a doctor assessed the man after he reported a burning pain in his stomach. The doctor prescribed omeprazole, an antacid medication. The next day, a nurse saw the man, who complained of weight loss and epigastric[1] pain. He was worried about feeling a lump in his throat and had difficulty swallowing. A locum prison doctor saw him on 11 November and noted that he had lost a stone in four weeks and that, if the pain and weight loss continued, he should be referred for an endoscopy. On 25 November, another prison doctor reviewed him and immediately referred him to hospital under the two-week rule (a target for people with suspected cancer to be seen by a specialist within two weeks), for suspected upper gastrointestinal cancer. He had an endoscopy on 8 December, which showed that he had oesophageal (throat) cancer.

21. The clinical reviewer considered that the man should have been referred immediately under the two-week rule when he first presented with 'alarm' symptoms on 4 November. He said:

> "His referral was three weeks later than could have happened had the healthcare professional recognised the seriousness of the symptoms."

22. We share the clinical reviewer's concern that the seriousness of the man's symptoms was not identified sooner and make the following recommendation:

The Head of Healthcare should ensure that clinicians working in the prison are familiar with and follow the national early diagnosis of cancer guidelines issued by the National Institute for Health and Clinical Excellence.

Informing the man about his condition and treatment

23. The prison received the results of the man's endoscopy on 12 December 2010. His medical records show that an appointment was made for 21 December, with a prison doctor. Although the medical records are not explicit about when he was first told of his initial diagnosis, it appears that the doctor told him at this appointment that he had terminal cancer, that a CT scan would be arranged and that he would be reviewed at the hospital.

[1] epigastric – upper central region of abdomen

24. On 11 January 2011, a prison GP also told the man that his cancer was inoperable and he would need additional tests and chemotherapy treatment. There is no documented information about his life expectancy, although his solicitors stated in subsequent correspondence that he did not wish to know this information. The clinical reviewer notes that there was no specific record of what information he was given about his treatment but considers that this would also not be unusual in community records. On 7 February, his consultant oncologist at hospital gave him further details about his tumour. On 25 February, she again told him that his cancer was inoperable and that chemotherapy would be palliative only.

25. At a review on 3 February 2012 with a locum prison doctor, the man expressed concerns about his prognosis. The doctor reiterated that his treatment was palliative as his tumour was inoperable. She said that if his tumour was still growing it would possibly indicate a reduced life span of under 12 months, but a consultant would need to confirm this.

26. It is unclear why there was a delay of nine days before prison staff informed the man of his diagnosis. We therefore make the following recommendation:

The Head of Healthcare should ensure that prisoners are informed promptly of the diagnosis of a terminal illness.

The man's medical appointments and treatment

27. The man had a further scan on 13 January 2011, followed by frequent appointments for chemotherapy and radiotherapy until his death. A stent was fitted on 14 February, to assist with his intake of food and liquids. On a few occasions, the hospital postponed his appointment but when this happened, they immediately notified a new date. On 18 February, he missed a hospital appointment, as he was too unwell to attend.

28. Prison staff reviewed the man's care needs each week. They also put in place a care plan, which was regularly reviewed and well documented, with two quality entries recording interaction with him each day.

29. The man's consultant oncologist wrote to the prison's healthcare department on 29 July and 24 August, expressing concern that he had missed appointments. On the latter occasion, she advised that he had not attended an appointment the previous day and had missed several other appointments, seemingly because of a lack of prison transport. She pointed out that failure to attend would have a negative impact on his care and asked the prison to address this. A member of the healthcare team telephoned the consultant's secretary to say that they had not received an appointment for 23 August and gave assurance that they would always facilitate his appointments. No mention was made of the other missed appointments that the oncologist had highlighted.

30. In a further letter to the prison dated 30 August, the consultant oncologist said she had reiterated to the man and the accompanying escort staff that it was

important for him to attend regularly. On the same day, he informed his personal officer that the hospital had told him that he had missed three appointments. They discussed whether he should make a formal complaint but, after considering this, he decided to raise the matter informally at a forthcoming healthcare appointment.

31. The consultant oncologist wrote again on 7 December, to say that the man had not attended his appointment on 25 November and that another planned for 12 December had been cancelled and rearranged for 6 January 2012, owing to staff illness (although unclear, it appears to have been illness of a member of hospital rather than prison staff). After the appointment in January, the consultant sent another letter to the prison drawing attention to the missed appointments and the importance of him attending all appointments.

32. At a multidisciplinary care plan review on 22 December, the man said that he was happy with the support and care given, but was concerned that he had missed a hospital appointment for treatment. It was agreed that in future he would be informed of any cancellations before the day of the appointment.

33. On 9 January, the man again asked to speak to his personal officer about missed appointments. He said that at a hospital appointment the previous Friday, his consultant had sternly advised him that he had missed five appointments and that by doing so he was undoing all the improvements gained from his previous treatment. He sought the officer's advice about how to handle this to ensure it did not happen again and they discussed the options open to him. He agreed to think about it. The officer noted:

> "I have offered to help him with the writing of anything as he is still struggling with the lack of feeling in his fingers which has not been helped by the fact that he had to have triple dose of chemotherapy to make up for what he had missed".

34. The man made a written complaint in January 2012 about missing hospital appointments between October 2011 and January 2012. He commented:

> "… It resulted in me having to have an extended treatment last Friday, which made me feel terrible. I am also upset because the consultant informed me that by missed treatments I am undoing all the good work previous ones have done and this is potentially life threatening for me…"

35. The response to his complaint indicated that a missed appointment in April 2011 was due to him declining to attend as his mother was due to visit. There was no reference made to the missed appointments that he had complained about in the latter part of the year. This was an unsatisfactory reply, which failed to address the issues raised in the complaint.

36. On 30 January, an oncology specialist at the hospital wrote to the prison to advise that a recent scan had shown a possible slight increase in the man's

tumour as well as the nodes around it and she thought that this might have been due to him missing some treatments.

37. The missed appointments interrupted the man's chemotherapy treatment and impacted adversely on his wellbeing as he felt extremely ill after the extended treatment. It is unclear exactly how many appointments were missed but most were attributable to the prison and continued after his oncologist had raised concerns about the issue. It is important that arrangements are made to ensure that those with serious or life-threatening conditions do not miss appointments and treatment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

The man's pain relief and medication

38. The man was prescribed tramadol and paracetamol for pain relief. When he developed problems swallowing tablets, his pain relief was changed to a liquid, soluble form. He also suffered with acid reflux and was prescribed esomeprazole to alleviate the symptoms. He collected his pain relief medication weekly and kept it in his cell. His diet was modified to soft food with liquid supplements.

39. A nurse noted that on the day of his death the man said his pain was not well controlled and asked for an increase in his medication. She submitted this request to the doctor but his condition deteriorated further that day and he was admitted to hospital.

40. The clinical reviewer commented in relation to pain relief:

> "There is considerable documentation in the medical records to demonstrate that he was regularly assessed and his treatment needs met. Regular care reviews were documented, including documentation of analgesia requirements."

41. We are satisfied that the man's pain relief and medication was appropriately managed and recorded in his care plan document.

Liaison with the man's family

42. The man had frequent contact with and visits from his family, who were aware of his terminal illness. He was admitted to hospital with breathing difficulties on several occasions in the months before his death. Prison records indicate that his family were informed of his hospital admission on one occasion.

43. On 18 June 2012, the man was admitted to hospital with breathing difficulties and hospital staff indicated that his death could occur within the next few days. The man's personal officer understood from the deputy governor that

he had indicated that he did not wish his family to be informed of his admission.

44. Two weeks before his death, the man changed his next of kin to a family friend as his mother was frail and he did not wish to upset her. His documents were updated appropriately.

45. On 13 August, the man was found in his cell coughing up blood and in severe pain. A nurse immediately requested an ambulance. He was taken to hospital shortly after 6.00pm. He asked the prison to contact the family friend nominated as his next of kin and an officer did so at 7.10pm. He subsequently died and hospital staff contacted his friend to break the news. A file note indicates that the deputy governor telephoned his friend at 4.50pm later that day to explain the procedures that would follow and advise that a family liaison officer would be appointed. The family liaison officer was appointed the next day, 15 August. She telephoned the man's friend that afternoon to give him information.

46. Prison Service Instruction 64/2011 states that the prison must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are seriously or terminally ill. We are satisfied that the man's family were generally kept informed about his condition, but it would have been good practice for the prison to have appointed a member of staff as a single point of contact for his family to get in touch with about any concerns.

47. The prison originally offered inadequate financial assistance towards funeral expenses and not in line with Prison Service guidelines. We are satisfied that this issue was later reconsidered and rectified by the Governor after we raised this with the prison.

The man's location

48. When the man was initially diagnosed with cancer, he was offered a transfer to HMP Exeter where there is 24 hour health cover. He declined, preferring to remain at Channings Wood. He occupied a standard ground floor single cell close to the bathroom, in a small residential self-contained unit (living block 7), where prisoners have a key to their own cell and have free movement around the corridors. At night, entrances to corridors are locked and the night officer does not patrol the unit. He indicated he wished to remain in living block 7 and did not want to return to his previous unit, living block 5, where prisoners are locked in their cells overnight. As his health deteriorated, he was given appropriate comfort aids such as an air mattress, incontinence sheets and a convector heater. When he was unable to walk to the visits room, he was given a wheelchair.

49. We consider the man's location was suitable for his needs at that time, as he felt well supported by friends and staff in his unit. Prison staff respected his wishes and he remained there until his death. The clinical reviewer concluded that on the basis of his condition, inpatient care at a hospital or hospice was

unnecessary.

Compassionate release

50. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and they are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).Release on temporary licence (ROTL) can be granted by the Governor.

51. A prison doctor recommended compassionate release on 8 March 2011. The process was started and an application was completed and submitted to the deputy governor on 6 June. However, on 16 August, the man was informed by a wing officer that his application had been rejected as his condition had stabilised but, should he deteriorate, compassionate release would be reconsidered. There is no evidence that this matter was revisited as his health deteriorated.

52. A Quick Time Learning Bulletin issued by the National Offender Management Service for all prison and healthcare staff (issue 7, June 2011) reinforced the importance of timing for compassionate release applications:

> "The timing of an application for early release on compassionate grounds is the key to a successful application. It should not be made too early at a point where life expectancy is not known, however, neither should it be left too late when there may be little chance of it being processed before the prisoner dies."

53. Compassionate release was recommended by the prison clinicians, but there is no record of the man's life expectancy in his prison records and the documents relating to the application in 2011 were not provided to the investigator. There is no evidence that the prison proactively sought information about life expectancy in order to determine whether such an application was appropriate after the initial refusal in August 2011.

54. The man's condition deteriorated rapidly on 13 August 2012 and he died within hours of admission to hospital. His escort risk assessment documents indicated that release on temporary licence had been considered by the Head of Security but not approved. No further information was recorded about the reasons for this decision.

55. Early release should be considered for all terminally ill prisoners and kept under review. No further consideration appears to have taken place after the initial refusal in August 2011, or after a hospital admission on 18 June, when staff were advised that the man might have only a few days to live. In view of the lack of clarity about the decisions relating to early release, we make the following recommendation:

The Governor should ensure that the possibility of early release on compassionate grounds is considered for all eligible terminally prisoners and kept under review. Actions and decisions about applications should be recorded in the prisoner's records.

Palliative care plans

56. On 17 February 2011, a doctor recorded that the man would be given only palliative chemotherapy. On 28 February, prison healthcare staff consulted the hospital about setting up Macmillan support for him and were told that a formal referral should be made. (Macmillan Cancer Support provides advice and support for those with cancer.) An entry in his care plan indicates that Macmillan was unable to provide support owing to a lack of resources but prison staff arranged for additional emotional and pastoral support through the chaplaincy.

57. The lead nurse in the man's care completed a care plan during a review with him on 4 March. The aim of the plan was to ensure that he had access "to the same range and level of health care palliative services as the general public". His expectations were to follow all treatment avenues, remain as independent as possible and remain on living block 7, where he felt he had good peer support and the officers adopted an empathetic approach. Staff were instructed to add entries to the care plan at least twice a day. The nurse also discussed the issue of an advance directive. (A statement that indicates a patient's wishes about medical treatment should they become acutely unwell and not have the mental capacity to make such decisions.)

58. Regular multidisciplinary meetings were subsequently held to review the care plan. They were attended by the deputy governor, a senior officer, an officer and the lead nurse or another healthcare staff representative.

59. A doctor examined the man on 16 March 2011 and was satisfied that he had the mental capacity to sign the advance directive indicating that he did not wish to be resuscitated in the event of a cardiac arrest. The signed directive was immediately faxed to Devon Doctors, the out of hours GP service, and circulated to all relevant staff a week later. He withdrew this directive on 16 August when his condition stabilised and no further advance directives were applied. His case notes were updated and staff informed.

60. We are satisfied that treatment care plans, put in place with the man's agreement, were well documented and regularly reviewed. The clinical reviewer concluded that, 'appropriate plans were in place and followed' and

that end of life care pathways were not needed before his sudden collapse and death.

Use of restraints

61. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

62. The man went to hospital six times between May 2012 and his death, on three occasions as an outpatient and the remainder as an unplanned emergency admission. Risk assessments for most of these hospital visits concluded that he presented a 'normal' risk of escape and to the public but little information was recorded to substantiate the decision as to the level of risk. (The levels of risk were categorised as low, normal and high.) The risk assessment form has a section to be completed by healthcare staff to indicate whether there are any medical objections to the use of restraints or any specific factors to be considered, such as the physical ability to escape. On each of the risk assessments, healthcare staff ticked to say there was no objection to restraints but made no comments about his condition or how this impacted on his risk as the court judgement requires.

63. Single handcuffs were used for the journeys to hospital, (with the exception of the final admission just before his death, when the head of security authorised no restraints during either the journey or his stay in hospital because of his poor condition and immobility). While at hospital, either an escort chain was used or the restraints were removed for medical treatment after approval was sought from prison managers. Sometimes such approval was sought several hours after he had arrived at the hospital. During an emergency admission on 18 June, the Head of Security authorised the removal of restraints after he was told that the man might die within a few days.

64. On the two occasions the Head of Security made decisions about the use of restraints (18 June and 13 August), he completed a "decision log for the care and use of restraints". We are pleased to note that this document was introduced in June 2012, as a result of previous PPO recommendations relating to the use of restraints with terminally ill prisoners. However, the man's mobility varied during the course of his disease. The healthcare and security assessments were not fully completed to give a full picture of his condition at the time of his hospital visits, neither were they kept under review. Without regular reviews and an appropriate contribution from healthcare staff the use of restraints cannot be fully justified. We make the following recommendation:

The Governor should ensure that risk assessments are fully completed and that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the prison healthcare staff are familiar with and follow the national early diagnosis of cancer guidelines issued by the National Institute for Health and Clinical Excellence.

2. The Head of Healthcare should ensure that prisoners are promptly informed of the diagnosis of a terminal illness.

3. The Governor and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

4. The Governor should ensure that the possibility of early release on compassionate grounds is considered for all eligible terminally prisoners and kept under review. Actions and decisions about applications should be recorded in the prisoner's records.

5. The Governor should ensure that risk assessments are fully completed and that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time.