

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at The Princess
of Wales Hospital, Bridgend, on
20 February 2013, while in the custody of HMP Parc**

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 on 20 February 2013, at HMP Parc. The man died of stomach cancer which had spread to other areas of his body. He was 59 years old. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. Healthcare Inspectorate Wales (HIW) conducted a clinical review of the man's care at Parc.

He was diagnosed with inoperable stomach cancer in December 2012. The prison acted promptly to seek a diagnosis and, although there were delays in achieving this, they were not attributable to the prison. The man declined chemotherapy to help control the disease and Parc provided palliative care to him until his death. .

I am satisfied that the man received a high standard of care at Parc and I agree with the conclusion of HIW that, once his condition was known to be terminal, his palliative care was exemplary and followed good practice for end of life care for prisoners. In addition to the clinical care, the prison staff responsible for liaising with his family were highly effective in facilitating frequent and good quality contact as well as timely information and support. I commend staff at Parc for the compassionate and caring approach taken with the man and his family, which was an example of good practice that other prisons would do well to emulate.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was convicted of serious offences in 2000, but absconded to Thailand while on bail awaiting sentence. He was re-arrested and extradited to Britain in April 2012 and subsequently sentenced to 12 years imprisonment at Cardiff Crown Court on 25 May 2012.
2. During initial health screens at Parc, he said that he had chest pains, a gastric ulcer and, in Thailand, had self-medicated for indigestion. Over a period of several months, he experienced stomach pains and other symptoms for which he was treated at Parc. However, his symptoms became more persistent and, in September 2012, a prison doctor made an urgent referral to Princess of Wales Hospital, Bridgend, for further investigations.
3. The hospital was slow to arrange the appointment but the man was eventually seen by a consultant on 9 November, and had an ultrasound scan and endoscopy. A CT scan on 19 November confirmed that he had terminal cancer of the stomach that had spread to other parts of his body. The hospital did not immediately communicate these findings, so he was not informed of the diagnosis until 18 December. He declined chemotherapy to help manage his condition.
4. After his diagnosis, staff at Parc provided a high standard of palliative care, as well as excellent advice and support for his family. This included flexible and frequent access to visits on the man's residential wing and overnight stays. The man died with his family at his bedside on 20 February.
5. Parc experienced difficulty with communication from the Princess of Wales Hospital. Despite continued efforts, prison doctors were often unable to obtain information about his appointments or test results in a timely manner which led to some delays. This was the responsibility of the hospital and outside the remit of this investigation. The clinical reviewer notes that the delays would not have made any difference to the outcome, but diagnosis should have been made earlier.
6. HIW has concluded that the way staff dealt with the man's care was exemplary. The actions by the staff involved in his care should be shared with other prisons as an example of good practice.

THE INVESTIGATION PROCESS

7. The Ombudsman was notified of the death on 20 February 2012. The investigator, issued notices to staff and prisoners at Parc informing them of the investigation and asking anyone with relevant information to contact him. No responses were received.
8. The investigator contacted Parc on 21 February, to request the man's records. The Health Inspectorate of Wales (HIW) conducted a review of his clinical care.
9. HM Coroner was informed of the investigation and advised that, owing to the nature of the death, an inquest was likely to take place before the conclusion of our investigation. A copy of the investigation report has been sent to the Coroner for information.
10. One of the Ombudsman's family liaison officers, contacted the man's family to explain the purpose of the investigation. His family did not have any specific concerns for the investigation to consider. Following the receipt of the draft report, the family chose not to comment on the findings of our investigation.
11. The investigation has assessed the main issues involved in his care, including his diagnosis and treatment, liaison with his family, his location, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP PARC

12. HMP & YOI Parc, which opened in 1997, is run by G4S. It holds more than 1,400 convicted male adult prisoners and young adults on remand or convicted. It also has a unit for around 60 young people under 18.
13. There are 24 hour primary general and mental healthcare services at Parc provided by G4S. The healthcare centre has a 14 bed unit for older prisoners and those with increased health needs where Smithers' lived when he was at the prison.

HM Inspectorate of Prisons (HMIP)

14. HMIP last completed a full unannounced inspection of Parc in September 2010. They found that prisoners were mostly positive about their relationships with staff. However, support for prisoners with disabilities was weak, with no clear assessment of individual needs or care plans. Inspectors reported that, at the time, healthcare services were not delivered to an acceptable standard. G4S was about to take over the provision of healthcare services when the inspection took place.

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board 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. In its most recent annual report, for 2011 - 2012, the IMB noted that the prison was well-run and safe, although they identified some problems with prisoners being made aware of medical appointments.

Previous deaths at Parc

16. There were five investigations into deaths at Parc in the year before this death, all were due to natural causes. There are no apparent similarities between the circumstances of this and the previous deaths.

ISSUES

17. The man was extradited from Thailand and remanded into custody on 27 April 2012. He had absconded in February 2000, while on bail awaiting sentencing, after being convicted of serious sexual offences. On 25 May 2012, at Cardiff Crown Court, he was sentenced to 12 years imprisonment for the original offences and, at the time of his death, was on trial for further offences. He was 59 years old.

The diagnosis of the terminal illness

18. At an initial health screen when he arrived at HMP Parc, the man said that he had no real concerns about his physical health but reported that he had experienced some chest pains in the previous months. While he was in custody in Thailand, a doctor had prescribed medication for this.
19. On 30 April, as part of the health screen process, he told a prison GP that he had a history of gastric ulcers. Despite his stomach pain, he was eating well and there was no family history of stomach cancer. He added that in Thailand he had been self-medicating with rantidine, a drug for indigestion which also reduces stomach acids. He said he had recently lost about 20kg in weight. The GP initially diagnosed "probably gastritis +/- gastro/duodenal ulcer disease". She prescribed lansoprazole, to reduce stomach acids and ordered blood tests which were subsequently returned as normal.
20. The man's stomach pain continued over the next few months. Prison doctors assessed him several times and prescribed medication which initially alleviated his symptoms. However, he began to experience discomfort more often and his symptoms worsened so another GP sent an urgent referral on 11 September, to the Gastroenterology Department at the Princess of Wales Hospital, Bridgend, for a gastroscopy (internal examination of the stomach with a small camera inserted via the mouth). A response was received a week later on 18 September. Although the referral was marked as urgent, the appointment was not listed until 9 November 2012.
21. In the meantime, the man reported more symptoms including stomach and back ache, constipation and vomiting. Further tests, including one for prostate cancer, were normal. A GP at Parc, thought that the man might have diverticular disease (an abdominal condition which causes pain and bloating) and made a further referral, on 5 October, to the Gastroenterology Department at the Princess of Wales Hospital but received no response. Additional tests and consultations with doctors at Parc took place in October and November.
22. At the hospital appointment on 9 November, the consultant recorded that an ultrasound scan was abnormal, indicating ascites (an excessive accumulation of fluid in his abdomen, which is always a sign of serious illness). An endoscopy (an internal examination of the stomach with a camera) had revealed a large gastric ulcer and suspected cancer. The consultant referred him for a CT scan, which was carried out on 19 November. This showed that he had cancer of the stomach, which had spread to surrounding tissues. In

spite of efforts by prison doctors to get the test results, they were not received at Parc until 7 December. HIW note that the scan results were vitally important to the doctors at Parc, but they were not immediately communicated to them as they should have been.

23. A GP who had been involved in the man's care at Parc, told the investigator and HIW that the issues with the appointments at the Princess of Wales Hospital were not unusual. He said that communication with the hospital was very poor and prison healthcare staff spent many hours each day chasing information. He explained that although the GPs at Parc have responsibility for the patients, information about their consultations at the Princess of Wales Hospital was not shared with them and patient confidentiality was usually cited as the reason.
24. HIW state that it is not possible to say when the man first developed cancer. He had been losing weight in Thailand but this was thought to be due to him being in prison. HIW conclude that the diagnosis should have been made earlier, but probably would have made no difference to the eventual outcome. They express considerable concern about the hospital's handling of the initial urgent referral, particularly the lack of communication, as well as delays in subsequent tests and investigations. The failings were not attributable to the prison and are outside our remit. The clinical review indicates that this is something HIW will need to take up with the hospital.

Informing the man about his condition and treatment

25. On 18 December, a specialist at the Princess of Wales Hospital told the man that he had inoperable cancer of the stomach that had spread to other areas of his abdomen. HIW notes that the specialist's letter following the appointment on 18 December addressed to the GPs at Parc, did not offer any support to the man, or mention other sources of support such as Macmillan nurses but pointed out that chemotherapy treatment might be possible at another hospital.
26. Later that day, when he returned to the prison, he told a nurse about his diagnosis and that he had been told that he had three to nine months to live. She notified the chaplaincy, as well as senior managers and arranged for a GP to see him the next day, 19 December. She noted that he shared a cell with a Listener with whom he got on well. (Listeners are prisoners trained by the Samaritans to provide support for fellow prisoners.)
27. At the appointment on 19 December, the GP discussed the options for the management of his condition and advised the man of the care he would be given as his condition deteriorated. The GP saw him again on 21 December and explained in detail the likely progression and outcome of his illness. HIW notes that the records throughout the man's terminal care were a very good indication that discussions had taken place and that he understood fully the decisions that had been taken and options open to him. We are satisfied that staff at Parc gave him full and timely information about his condition and treatment options.

The man's medical appointments and treatment

29. The man's hospital consultant referred him to an oncologist on 18 December 2012. The appointment had not been received by 3 January 2013, so the prison contacted the Velindre Trust (the NHS Trust in South Wales which deals with cancer treatments), which subsequently made an appointment for 17 January.
30. On 4 January, prison healthcare staff drew up and implemented a care plan for him. This included strategies to address poor appetite and reduced ability to eat and drink; reduced mobility; general deterioration; pain and hygiene. It was agreed that he would be monitored every four hours. Entries in his medical records show that on most days he was seen frequently by nurses and at least once a day by a doctor. The GP recorded on 7 January that he had consistently refused to consider chemotherapy.
31. At his hospital appointment on 17 January, a specialist registrar, had a detailed discussion with him about his diagnosis and reiterated that his cancer was incurable. He advised that the aim of chemotherapy was to control the disease and not cure it. The man said he did not wish to receive any further treatment, so the doctor discharged him. We are pleased to note that an appropriate security risk assessment was completed for this hospital appointment and restraints were not used.
32. We are satisfied that the prison made timely attempts to secure treatment for the man, including pursuing an alternative oncology appointment as the original referral by his consultant had not been dealt with promptly. The man exercised his right not to have treatment.

Pain relief and medication

30. After his discussion with the man on 19 December, the day after his diagnosis, The GP prescribed dihydrocodeine, a strong painkiller. On 3 January, after a bout of vomiting and abdominal pain, the GP started him on morphine in the form of modified release tablets - MST, which release morphine slowly over 12 hours, twice a day. The next day, the same doctor increased the MST at night and wrote prescriptions for diamorphine injections (for pain), hyoscine injections (to reduce secretions) and cyclizine injections (for nausea and vomiting), to be used as required.
31. His medication was reviewed daily and adjusted as necessary. HIW notes that he was given the correct drugs for his symptoms both before and after his diagnosis and we are satisfied that this was managed appropriately.

The man's location

32. At the time of his diagnosis, the man lived on a standard residential wing. During their discussion on 19 December, the GP gave him the option to move to the assisted living unit (U block) at Parc. This is a small unit accommodating around 14 prisoners, most of whom are elderly or require assistance with normal daily routines. The cells in the unit have ensuite toilets and showers. He initially decided to stay on his wing but moved to U block just after Christmas, on 27 December. He was the first prisoner receiving palliative care to be located on that unit.
33. Staff on U block liaised with healthcare staff to gain a better understanding of his needs as his illness progressed and also arranged training by Macmillan nurses, who came into the prison to provide support. On one occasion, consideration was given to moving the man temporarily to a palliative care unit at the Princess of Wales Hospital. No beds were available but the symptoms that had originally triggered this request settled down and it was no longer necessary. Doctors advised him of the circumstances under which he would be transferred to a hospital or hospice. On 27 January, a GP offered him the option of going to a hospice but he declined.
34. HIW notes that it was clear that every effort was made to meet the man's needs. He had a hospital bed and a special mattress. An 'open door' policy was agreed as soon as he moved to U block, which meant that his cell door remained open throughout the day and night to provide immediate access to staff. We agree with HIW that staff made appropriate accommodation arrangements for him.

Palliative care plans

35. As soon as the man's diagnosis was known, the prison acted quickly to inform him about his illness and put in place appropriate care plans. The GP had a long discussion with him about palliative care on 21 December 2012, including the subject of resuscitation in the event of cardiac or respiratory arrest and placed him on the palliative care register. At that time, he did not wish to sign a DNAR (do not attempt resuscitation) form but he subsequently changed his mind on 4 January 2013. Appropriate medication was prescribed.
36. Staff held a review case conference on 8 January, after the man had found that he was overwhelmed by the number of visits he was receiving each day, including those from other prisoners who wanted to support him. The man asked to see the doctor daily to review his pain control. It was also agreed that he would have four hourly observations and the nurse would visit each lunchtime and late afternoon. On 18 January, the GP suggested that the man might need a syringe driver (a small machine which delivers pain relief medication slowly and regularly) over the next week. A syringe driver was used from 23 January, the first time that one had ever been used at Parc. Both healthcare staff and officers on U block were given awareness training on the use of syringe drivers.

37. As his condition deteriorated, prison healthcare staff sought help from the palliative care service at the Princess of Wales Hospital and a consultant, visited the man on 28 January 2013. The specialist wrote up a full care plan, which was converted into an end of life care pathway on 30 January. HIW notes that this pathway was continued and acted upon until his death, which is regarded as good practice.
38. HIW found that records were very good and reflected when discussions took place, the decisions taken and their implications and that he understood what he had been told. We are satisfied that the man received a good standard of palliative care.

Compassionate release

39. Early release on compassionate grounds (ERCG) 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 is that prisoners 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) within the National Offender Management Service (NOMS). Applications submitted are expected to be supported by the Governor or Director.
40. On 22 January 2013, Member of Parliament for Ogmore, wrote to the Director of Parc, on behalf of the man's family, who had raised the possibility of him being released on compassionate licence. The Director responded on 30 January, setting out the usual process which would be followed in such cases. She also advised that, due to his sentence, further serious charges and perceived level of risk any application for him was unlikely to be successful.
41. The Director explained to the investigator that the initial concerns were that the man had recently been sentenced and had also been charged with further serious offences. He had absconded following his conviction in 2000 and therefore was considered to pose a 'high risk' if released on licence. While the prison management team had not submitted an application, consultation had taken place with other agencies, such as the National Probation Service, about the likely success of the application if submitted.
42. We are satisfied that the prison explored the possibility of applying for the man to be considered for release on compassionate grounds but he did not meet the criteria.

Liaison with the man's family

43. As soon as he was diagnosed with terminal cancer, a nurse advised the chaplaincy and operational managers of his condition. The Complex Case Manager in the prison's safer custody team, was then appointed as the family liaison officer. She said that he was happy to discuss his diagnosis with her. They discussed his family and she offered to invite them to the prison so that he could tell them face to face rather than by telephone. The man had already booked a visit with his family for the next day. The manager accompanied the man's family to the visits room, as the man had asked her to tell his family if he felt unable to do so. In the event, he was able to tell them and she left him with his family to discuss his situation together.
44. A member of the prison chaplaincy, and the manager built a good rapport with the man's family. They kept them informed of his care, answered questions and offered ongoing support, including discussion about his plans for his funeral. The healthcare team also regularly updated his family about his condition. As his family were unable to care for him at home, the prison relaxed the usual security protocols to allow his family frequent access to visits on his residential unit outside normal visiting times, including in the evenings. They had the opportunity to remain with him overnight and had almost constant access in the last few days of his life.
45. When his condition deteriorated, prison staff immediately notified his family and they were with him when he died in the early hours of 20 February. After his death, the prison continued to support his family and a prison chaplain officiated at his funeral at their request. The prison also offered financial support to help meet the costs of the funeral.
46. We note that the prison facilitated contact with the family as soon as his diagnosis was known and they supported him in telling his family about his illness. Prison staff also communicated with his family frequently and allowed them easy access to visit him. We consider that the staff involved demonstrated flexible and commendable practice in family liaison.