
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at a hospice in
March 2013, while a prisoner at HMP High Down**

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 at a hospice in March 2013 while in the custody of HMP High Down. He died from stomach cancer. He was 44 years old. I offer my condolences to his family and friends.

A clinical review was carried out on the clinical care the man received in custody. HMP High Down and HMP Coldingley cooperated fully with this investigation.

The man had a history of heartburn and chest pain. He was referred to hospital and tests conducted in December 2012 suggested his pain was musculoskeletal. In February 2013, his symptoms worsened and he was again referred to hospital where he was diagnosed with inoperable cancer. On 21 February, he transferred from HMP Coldingley to HMP High Down where there is a 24 hour healthcare service. On 7 March, he was taken to hospital when his condition deteriorated. He was moved to a hospice in March and died the same day.

I agree with the clinical reviewer that the care the man received in prison was equivalent to that he might have expected to receive in the community. However, the investigation also found that sufficient priority was not given to pursuing compassionate release and that the use of restraints when he went to hospital was not always justified by a fully considered and up to date risk assessment.

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

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SUMMARY

1. The man died in March 2013 at a hospice while he was a prisoner at HMP High Down. He was 44 years old. A post-mortem report recorded his cause of death as due to stomach cancer.
2. On 21 December 2010, the man was sentenced to nine years imprisonment. In November 2010, he told the prison doctor he was suffering from heartburn and chest pain. He was treated for oesophageal reflux (where stomach acid leaks out of the stomach and into the gullet) and prescribed omeprazole to reduce the acidity in the stomach.
3. On 14 January 2011, the man transferred to HMP Coldingley. He was later held at HMP Dartmoor and HMP Guys Marsh before returning to Coldingley on 24 October 2012. During this time, he had several episodes of upper respiratory tract infections and was prescribed antibiotics. There were no other significant healthcare issues during this period.
4. In December 2012, after complaining of chest pains, the man was taken to the rapid access chest pain clinic at hospital. The hospital carried out tests and concluded that his discomfort was musculoskeletal (affecting the body's muscles, joints, tendons, ligaments and nerves).
5. On 2 February 2013, the man was seen by healthcare staff as he was experiencing heartburn. He saw a prison doctor on 7 February, who referred him to the gastroenterology service at hospital. On 9 February, he was taken to hospital with severe stomach pains and returned to the prison the same day.
6. On 12 February, the man was admitted to hospital for tests as he was experiencing increased pain. On 21 February, a hospital consultant told him that he had advanced stomach cancer and had a prognosis of up to a year to live. The plan was for palliative chemotherapy. He was transferred to HMP High Down as it could offer 24 hour healthcare.
7. On 7 March, the man was admitted to hospital and later to another hospital. He was restrained in hospital by an escort chain and, despite his rapidly deteriorating health, he remained restrained until the day before he died. On the day of his death he transferred to a hospice, where he died at 1.50pm the same day. His family were with him at the time.
8. We are satisfied that the standard of care given to the man was comparable to that he could have expected in the community. However, the continued use of restraints when he was in hospital was not justified and the risk assessment should have been revisited sooner to reflect his deteriorating health.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death in March 2013. The investigator issued notices at High Down informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No responses were received.
10. The local PCT commissioned a clinical reviewer to review the man's clinical care in custody. He received a copy of the man's prison medical record.
11. The investigator visited High Down on 22 March and met the Governor and spoke to other staff involved in the man's care. He examined all his relevant prison records, including his prison medical records. He interviewed staff and prisoners on 15 and 25 April. Initial feedback was given to the security manager at Coldingley and the custodial manager at High Down on 14 May 2013, and subsequently followed up in writing. At the draft report stage the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations.
12. HM Coroner for Surrey was informed of the investigation and provided a copy of the post-mortem report. The Coroner has been sent this investigation report.
13. One of the Ombudsman's family liaison officer attempted to contact the man's family by telephone and letter to explain the purpose of the investigation and to invite them to identify any relevant matters they wished the investigation to consider. We were later contacted by their representative, but at the time of writing they had not identified any specific issues for the investigation to consider. The family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. 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.

HMP COLDINGLEY

15. HMP Coldingley is a Category C prison¹ near Woking which can hold just over 500 male prisoners. There is a healthcare centre with services similar to a GP surgery. There is no in-patient healthcare facility and prisoners with increased healthcare needs are transferred to nearby prisons with appropriate facilities.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons' (HMIP) last published inspection report of Coldingley was of an inspection in June 2010. The report or a more recent inspection has not yet been published. The 2010 inspection report found that despite a more challenging population, the prison was a safe place. HMIP noted that the health care centre was a good facility for the treatment and care of patients, and was well managed with well organised clinics.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In the latest published annual report the IMB commented that the medical facilities were insufficient for those with a high level of medical need.

HMP HIGH DOWN

18. HMP High Down is a local prison near Sutton which holds up to just over 1,103 male prisoners. Healthcare services at the prison are commissioned by NHS Surrey and provided by Virgin Health. There is a 23 bed inpatient unit.

HM Inspectorate of Prisons

19. HMIP last inspected High Down in July 2011 and judged that that healthcare provision was very good and supported by an impressive level and quality of staff. Prisoners were generally satisfied with the access to healthcare services.

Independent Monitoring Board (IMB)

20. In their latest published annual report, the IMB at High Down was positive about the provision of healthcare and described it as "excellent with progressive improvements in all areas, despite budget constraints".

Previous deaths at High Down

21. Since 2010, the Ombudsman has investigated five deaths through natural causes at High Down. None of the previous investigations raised any issues which are pertinent to the man's death.

¹ Category C prisoners are those who are not judged ready for open conditions but who are unlikely to escape and do not require high security.

ISSUES

The diagnosis of the man's terminal illness

22. The man had a history of suffering from occasional indigestion, but in December 2012 his symptoms began to worsen. Initially, as his pain could have been cardiac related, he was referred appropriately to the rapid access chest pain clinic at hospital. The hospital said the pain was "musculoskeletal chest pain".
23. On 2 February 2013, the man attended the healthcare centre at Coldingley as he was experiencing heartburn. He had tried antacids and reported a burning feeling around his stomach area. On 7 February, a prison doctor diagnosed possible indigestion and prescribed omeprazole (to reduce stomach acid) but decided to refer him to the gastroenterology service at hospital. On 8 February, he was taken to hospital with severe stomach pain and was diagnosed with dyspepsia (indigestion). He was prescribed codeine phosphate to relieve the pain and advised to take gaviscon. He returned to Coldingley the same day.
24. The doctor saw the man again on 11 February and she recorded that he had "severe dyspepsia (indigestion) and weight loss". She ordered blood tests; and amended the referral to the hospital to an urgent two week cancer referral.
25. On 12 February, a prison doctor saw the man, who had deteriorated further and reported experiencing pain when passing urine and had problems with his bowels. The doctor arranged an emergency admission to hospital for further assessment and tests.
26. On 14 February, hospital staff told the man that it was likely that he had cancer but further tests would be needed to confirm the diagnosis and prognosis. On 21 February, he was formally diagnosed with metastatic gastric (stomach) cancer.
27. The clinical reviewer noted that gastric cancer is the second most common cause of cancer related deaths and is difficult to diagnose, often only becoming apparent when the disease is advanced. He was satisfied that the man received similar care to that which he would have received in the community and that he would not have expected the diagnosis to have been made sooner.

Informing the man about his condition and treatment

28. On 14 February, a consultant in palliative medicine at hospital informed the man of the possible diagnosis of cancer. He was understandably distressed and was initially monitored under suicide and self-harm procedures until 19 February when he made it clear he had no plans to harm himself.
29. The consultant saw the man again on 21 February and confirmed the diagnosis of cancer. He told him that the cancer was advanced and aggressive. His condition was inoperable and could not be cured and he could only be given palliative care to make him more comfortable. The consultant indicated that he might have up to a year to live.

30. Entries in the man's medical records note that he was aware of his diagnosis and the seriousness of his condition. We are satisfied that he was fully informed about his condition and was aware that no active treatment was possible.

The man's medical appointments and treatment

31. There were no plans for any further active treatment. The plan was to treat the man palliatively with appropriate pain relief where necessary.
32. On 7 March, the man was admitted to hospital because of increasing jaundice and to consider palliative chemotherapy. He was transferred to another hospital on 11 March for a surgical procedure. (The operation was cancelled on 14 March and it does not appear that it was ever carried out.)
33. The man's condition continued to deteriorate further. He later moved to a hospice and died there that day.

The man's pain relief and medication

34. When the man arrived back at Coldingley on 14 February, with a potential diagnosis of cancer, he was prescribed oramorph (liquid morphine) and tramadol (opioid medication for moderate to severe pain). He was also given co-codamol tablets for use during the night.
35. On 17 February, a nurse saw the man, who had concerns about his pain relief. He had been told that he could have top-up relief every two hours during the day. He was worried that masking his pain might not help his recovery. He was advised about this appropriately.
36. A doctor reviewed the man's pain management on 19 February and added slow release morphine to his prescription. He was also given a laxative to ease constipation, a side effect of the pain relief medication.
37. On 21 February, after the man's terminal diagnosis was confirmed, the consultant discussed his treatment with the Healthcare Manager at Coldingley. They agreed that Coldingley would be unable to manage his pain control at night so he transferred to High Down about 6.00pm that evening.
38. The man received medication for pain relief, constipation and vomiting for the next two weeks. On 3 March, an out-of-hours doctor prescribed suppositories to relieve his constipation and an anti-sickness injection.
39. On 4 March, the man was prescribed a morphine patch instead of oral pain relief as he was suffering from vomiting. A doctor from the hospice visited him on 6 March to review his medication. The doctor prescribed haloperidol to help relieve vomiting and nausea.

40. In his report, the clinical reviewer states:

“Appropriate treatment was provided and titrated [adjusted until the desired effect is reached] upwards; nevertheless the man did experience considerable pain in his last few weeks. He also experienced constipation and vomiting which were treated ... expert advice from the palliative care physician from the hospice was involved.”

41. Although the accounts would suggest that pain control was not always optimal, the clinical reviewer’s opinion is that the overall approach to pain management was of the standard expected. The prison liaised with and obtained specialist advice from the hospice to help ensure that the man’s pain was managed as effectively as possible.

Palliative care plans

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. Among the benefits of an end of life pathway are that 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.

43. The man was fully consulted about palliative care and end of life plans. The hospital, hospice and the prison worked well together to ensure that there was an effective care plan in hospital and in prison. Healthcare staff implemented all relevant care plans alongside an end of life pathway.²

44. The man was aware of his condition and prognosis and the records show that he and his family were involved in and informed of his care plans. The plans were followed and reviewed regularly. The clinical reviewer says that all of his care needs appear to have been met and palliative medication was prescribed as required. We are satisfied that there were appropriate plans for his end of life care.

Liaison with the man’s family

45. The man himself, hospital staff, and staff at Coldingley and High Down, kept his family informed about his condition.

46. The man’s family were able to visit him in hospital and at the hospice on the day he died. The prison chaplain visited him a number of times and was appointed as the prison’s family liaison officer shortly before he died. After his death she and one of the managers at High Down visited his family to offer support. The

² An end of life pathway is a model of care which enables healthcare professionals to focus on care in the last hours or days of life when a death is expected. It is tailored to the person’s individual needs and includes consideration of their physical, social, spiritual and psychological needs.

chaplain maintained contact with his family for continuing support and, in line with national policy, offered financial assistance towards funeral expenses.

47. 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. Although we are satisfied that the man's family were kept informed about his condition, 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.

The man's location

48. When the man was diagnosed with terminal cancer he was appropriately transferred to the inpatient unit at High Down to allow more effective nursing and pain management. One of the nurses at Coldingley told the investigator that the man had said he did not really want to go to High Down, but he understood the need and was grateful for the support he had had from healthcare staff at Coldingley.
49. At High Down, the man was allocated a cell in the inpatient unit where healthcare staff were able to monitor his condition and health needs regularly. His cell was on the ground floor and near to the wing office.
50. On 7 March, the man went to hospital, first to a hospital in Sutton and then on 11 March to a hospital in Carshalton. When his condition deteriorated further he moved to a hospice. He had his own room and his family were able to be with him when he died there later that day.
51. We are satisfied that the man's location was always appropriate for his needs. After his diagnosis, he moved to High Down where there was 24 hour nursing care. Once his condition deteriorated, he was admitted to hospital before moving to a hospice shortly before his death.

Early release on compassionate grounds

52. Early release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is 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). A decision to release someone early is rare.
53. The man's terminal illness was not confirmed until 21 February and the prognosis at that time was that he had up to 12 months to live. On 24 February, his sister wrote to request compassionate release for her brother and said that

he had been told he had between two to 12 months to live. The application for release on compassionate grounds required wide consultation to take into account, among other considerations, his family and victim issues. His offender manager was asked for a report and a medical opinion was needed on his life expectancy.

54. The offender manager's report was received on 15 March. On 18 March, the prison informed the public protection casework section that they would be making an application for release on compassionate grounds. However, confirmation on the man's life expectancy had not yet been received. Unfortunately, he died the following day, before the application could be progressed any further. The prison had intended to agree release on temporary licence from 19 March, but sadly he died before this was arranged. .
55. We are not satisfied that sufficient priority was given to obtaining information about the man's life expectancy and the application for compassionate release was delayed as a result.

The Governor should ensure that all required information is sought and obtained promptly to support applications for compassionate release

Restraints and security

56. 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. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.
57. 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 restraining by handcuffs of 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. The judgement required that a fresh risk assessment should be conducted each time a seriously or terminally ill prisoner is moved or their clinical condition is reviewed in order to assess the appropriate level of restraint for transportation to or from hospital.
58. When the man went to hospital on 7 March, an initial risk assessment concluded that he was a "normal" risk of escape and harm to the public (the risk assessment form has three levels of risk: low/normal/high). The risk assessment shows that he should be handcuffed while travelling to and from hospital and then restrained by an escort chain when he was in hospital. Two officers were to remain with him. Although still mobile on 7 March, he was

terminally ill, weak and in pain and it is not apparent that a medical opinion of how his health impacted on his risk was considered at the time, as the court judgement requires.

59. A risk assessment dated the day before the man's death, authorised by the Head of Safety at High Down, still did not contain any medical assessment and concluded that the man should remain restrained by an escort chain. Unaccountably, it clearly stated that he should be double cuffed if moved when previous assessments had required single cuffs. The escort log shows that on the afternoon of 18 March, a doctor contacted the prison to talk about his condition. Shortly afterwards at 2.55pm, a Supervising Officer contacted the escort staff to instruct them to remove the escort chain on the authority of the Head of Safety. After he moved to the hospice on 19 March, the level of escort was reduced to one officer in plain clothes.
60. After he was admitted to hospital on 7 March, the man's condition quickly deteriorated. The medical condition and mobility of a prisoner needs to be fully considered as part of the decision making process and levels of restraint must be proportionate to actual security risks, balanced by considerations of care and decency. It does not appear that this was done. Despite his failing health the risk assessment the day before he died indicated that he should remain restrained by an escort chain and that double-cuffs should be used if he was moved. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like him, the Prison Service requires that reasons should be recorded in writing. We can see no reason why this level of security could be justified when he was clearly very ill and dying.
61. We are not satisfied that risk assessments took into account the man's actual condition at the time, informed by medical opinion about his risk, and it was not until a hospital doctor telephoned the prison on the afternoon before his death that restraints were finally removed.

The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

RECOMMENDATIONS TO THE GOVERNOR OF HIGH DOWN

1. The Governor should ensure that all required information is sought and obtained promptly to support applications for compassionate release
2. The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

ACTION PLAN: The Man – HMP High Down

No	Recommendation	Accepted/Not accepted	Response	Target date for completion
1	The Governor should ensure that all required information is sought and obtained promptly to support applications for compassionate release	Accepted	In accordance with Prison Service Order 6000 - <i>Early Release on Compassionate Grounds (ERCG)</i> , 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. A local protocol will be put in place outlining the process involved for considering applications for ERCG. The protocol will make it clear that all required information from medical experts and multi-agencies should be sought and obtained promptly.	30 September 2013
2	The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.	Accepted	<p>The risk assessment is completed by security in consultation with healthcare managers. The healthcare manager will provide a medical assessment for prisoners considered terminally ill or coming towards end of life. A new risk assessment will be conducted and considered each time a seriously or terminally ill prisoner is moved and or when their clinical condition is reviewed in order to assess the appropriate level of restraint for transportation to or from hospital. Risk assessment for removal of restraints will require approval by the Governor or Deputy Governor.</p> <p>The Local Security Strategy will be reviewed and amended to reflect this.</p>	30 September 2013