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 April 2013 at hospital, while a prisoner at HMP & YOI Moorland.

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 at hospital in April 2013 while a prisoner at HMP & YOI Moorland. The cause of death was metastatic pancreatic cancer. He was 68 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to review the clinical care the man received in custody. HMP & YOI Moorland cooperated with this investigation.

The man had been in prison since 2006. He suffered from cardiac failure, raised cholesterol, depression, Alzheimer's disease and dementia. As a result, he was seen frequently by healthcare staff. In April 2013, staff noticed that he was very pale and yellowy and referred him for tests. The results were abnormal, and he was admitted to hospital the same day for a scan. He was diagnosed with primary cancer of the pancreas and secondary cancer of the liver within days.

The clinical reviewer considers that the man's care in Moorland was equivalent to that he could have expected to receive in the community and I agree. The report makes a small number of recommendations for improvement but, overall, he received a good standard of care at Moorland.

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**

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SUMMARY

1. The man received an indeterminate sentence in June 2006 for serious offences. He had been at HMP Moorland since December 2011 having been transferred from HMP Leeds.

2. The man had a number of conditions including cardiac failure, raised cholesterol, depression, Alzheimer's and dementia for which he was seen regularly by healthcare.

3. Over 2011 and 2012, his weight seemed to fluctuate and his warfarin (anti-coagulant) therapy had to be adjusted. The man's mental state caused concern and he was allocated a wing 'buddy' to help him with certain tasks and an elderly person care plan was implemented.

4. On 3 April 2013, a nurse noticed that the man was pale and a yellowy colour and alerted healthcare. On 4 April, the prison GP carried out tests and arranged for him to be admitted to hospital. An ultrasound scan on 5 April revealed a shadow on his liver.

5. On 8 April, following further tests, doctors at the hospital told the man that he had primary cancer of the pancreas, secondary cancer of the liver and that there was no available treatment.

6. Hospital staff were initially keen to discharge the man. Prison and healthcare staff looked at a number of options, including compassionate release or caring for him in a specially furnished palliative suite at the prison.

7. On 8 April, the man was released on temporary licence to hospital and the prison began enquiries to contact his family. He had been estranged from them for some time but contact was eventually established.

8. The man died in hospital at the end of April. His family were notified although there was a delay in doing so.

9. The Coroner gave the cause of death as metastatic pancreatic cancer.

10. The man was dealt with compassionately and efficiently once it became clear he was unwell. However, there was a delay in contacting his family following his death and the compassionate release process was delayed. We are also not convinced that it was necessary to restrain him when he was initially taken to hospital. We make two recommendations.

THE INVESTIGATION PROCESS

11. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact her. No one came forward.

12. The investigator visited HMP & YOI Moorland on 2 May 2013 and spoke to the prison family liaison officer, the head of residence, the healthcare manager and a prisoner friend of the man's. She also spoke to representatives from the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). She obtained copies of his prison and prison healthcare records.

13. The local PCT appointed a clinical reviewer, a nurse who specialises in cancer care, to review the man's clinical care in prison. She was provided with his prison healthcare records.

14. The investigator and the clinical reviewer interviewed three members of staff on 10 July.

15. HM Coroner for South Yorkshire East District was informed of the investigation and provided the cause of death. A post-mortem was not carried out. The Coroner has been sent this investigation report.

16. The man was not in contact with his family. One of the Ombudsman's family liaison officers contacted his ex wife to explain the purpose of the investigation and invite his family to identify relevant matters they wished the investigation to consider. She did not wish to raise any matters or be kept informed about our investigation.

17. 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.

18. The prison considered our draft report and recommendations and has accepted these. No factual inaccuracies were raised. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.

HMP & YOI Moorland

19. HMP & YOI Moorland is a Category C training prison in South Yorkshire. It holds up to 1000 adult and young adult male prisoners, including 300 places in accommodation restored after the disturbances of 2010, which now mainly houses sex offenders.

20. Health services are commissioned by NHS Doncaster and provided by Nottinghamshire Healthcare NHS Trust. Services cover primary care, mental health and substance misuse. The facility does not have any inpatient beds so there is no 24 hour nursing cover, but an out of hours service is available.

Her Majesty's Inspectorate of Prisons

21. Her Majesty's Inspectorate of Prisons (HMIP) conducted an unannounced full follow-up inspection of Moorland in 2012. HMIP found that overall Moorland had made some progress despite some uncertainties about its future. However, HMIP reported that the pace of progress was disappointing and that there was much work to be done.

22. The quality of health services had improved but the environment did not meet infection control standards. Too many external appointments had to be cancelled because of staff shortages. Partnership and clinical governance arrangements were good and a wide range of clinics, which were part of the wing-based service, were available. Prisoner healthcare representatives were effectively used on houseblocks 3 and 4. Pharmacy services were also reported to be reasonably good.

Independent Monitoring Board

23. Each prison in England and Wales has an Independent Monitoring Board (IMB) 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 their latest published report, the IMB for Moorland noted that the prison had handled the opening of houseblock 6 and the introduction of vulnerable prisoners from all over the country, well. However, little provision had been made for appropriate staffing levels in healthcare, resulting in too much reliance on agency staff.

Previous deaths at Moorland

24. The last death at Moorland was in 2008. None of the recommendations made at that time are relevant to the circumstances of the man's death.

ISSUES

The diagnosis of the man's terminal illness

25. The man transferred from HMP Leeds to Moorland in December 2011. While at Leeds, his healthcare had focussed on managing his cardiac condition (he had been diagnosed with cardiac failure and raised cholesterol in June 2006) and his depression.

26. In the June of 2009, and again in the August of 2010, it was noted that the man's alkaline phosphate levels were raised. This can indicate a serious illness, such as liver or bone disease, but sometimes increased levels can be caused by medication.

27. In June 2011, the man's weight was recorded as 10 stones and seven pounds. He had lost weight, but it was noted that there were no indications of any serious problems and his weight loss was thought to be related to his depression.

28. The clinical reviewer asked the GP at Leeds about the increased alkaline phosphate levels and his weight loss and was satisfied that they did not relate to any underlying malignancy. She noted that in fact the symptoms eventually improved over time and that there was a 15 month gap between them settling and his eventual symptoms of cancer.

29. On 3 April 2013, a community in-reach nurse at Moorland noticed that the man had a yellow tinge to his eyes and was slightly pale and yellowy. She made a note to discuss her findings with the nursing team and a doctor in healthcare. She also spoke to an officer on the wing and one of his friends, who told her that he had urinated on the floor and was spending more time on his bed.

30. On 4 April, the nurse tested the man's urine and requested that the GP see him urgently to test his blood. On 5 April, two doctors saw him and blood tests, liver function tests and serum tests were done. The results were abnormal and arrangements were made for him to be admitted to hospital.

31. The man was admitted to hospital on 5 April and the next day an ultrasound scan showed a shadow on his liver.

32. On 7 April, a doctor at the hospital discussed a possible diagnosis of cancer with him and on 8 April the man was told that he had primary cancer of the pancreas, secondary cancer of the liver and an acute gall bladder infection.

35. The clinical reviewer looked at the man's various symptoms over the preceding months prior to his diagnosis of cancer. She considered

whether any of these could have indicated malignancy. She noted that abdominal symptoms, anorexia and weight loss and blood clotting problems can be indicators of problems related to both the upper and lower gastrointestinal tract and hepatobiliary (liver, gall bladder and bile ducts) system. However, she states that one would expect to see a consistent picture of progressive worsening of these symptoms over time. This was not the case with him. We are satisfied that he was appropriately referred and diagnosed once the jaundice developed.

Informing the man about his condition and treatment

36. The man was diagnosed in hospital and did not return to prison. He was told about his illness, prognosis and the lack of available treatment by hospital staff.

37. However, prison healthcare staff maintained contact with the hospital and also frequently visited the man. A nurse told us that, on one occasion, she had a long chat with him to ensure that he understood the nature of his illness and what was happening to him. We were also told that another team from healthcare had been to visit him specifically to explain his prognosis, which was commendable.

The man's medical appointments and treatment

38. The man did not have any appointments or treatment relating to his to his cancer prior to the admission to hospital in April, where the diagnosis was made. He did not return to the prison after this admission. Hospital care is outside the remit of the Ombudsman.

The man's pain relief and medication

39. The man's pain relief and medication was monitored and administered by the hospital.

Liaison with the man's family

40. On 8 April, when the man was given the diagnosis and prognosis, the residence manager on his house block started the process of trying to contact his family.

41. The man and his wife were divorced and he had not been in recent contact with either his wife or children.

42. The residence manager made a number of enquires including speaking to a victim support officer, who was able to contact the man's ex-wife.

43. On 10 April, the victim support officer visited the man's ex-wife, who asked her to only contact them once he had died.

44. The man died towards the end of April. There was some confusion over his next of kin details and the victim support officer's input and details had not been recorded. No family liaison officer was appointed.

45. Eventually, the residence manager was approached and he advised that the victim support officer should be told about the death as she was in touch with the man's ex-wife, his next of kin. However, as it was a weekend, she was not available on her office number and no emergency number for her was known.

46. Eventually, on Monday 29 April, the victim support officer telephoned the man's ex-wife to tell her that he had died. Arrangements were made for his family to meet prison staff to collect his possessions. In line with national guidance, the prison offered to make a contribution towards the funeral,

47. The man's ex-wife asked for no further contact from the prison, although she expressed her gratitude for their sensitive handling of events.

48. It is disappointing to learn that, after effort had been made early on to identify the man's family and prepare them for what was to come, a proper plan was not in place to notify his family once he died. A named family liaison officer had not been appointed and there was no plan for getting in touch with the victim support officer out of hours.

49. Prison Service Instruction (PSI) 64/2011 clearly states that it is good practice to appoint a family liaison officer as soon as someone is diagnosed with a serious or terminal illness. If Moorland had done so, the confusion over contact with the man's next of kin may not have arisen.

The Governor should ensure that accurate next of kin details are maintained and a named family liaison officer is appointed as soon as someone is diagnosed with a serious or terminal illness, in line with PSI 64/2011.

The man's location

50. The man was diagnosed with cancer in hospital and did not return to the prison. However, the healthcare team were conscious that the hospital was keen to discharge him, if at all possible. It is pleasing to note that staff tried hard to plan for his possible return to the prison.

51. This included setting up a palliative care suite at Moorland. Funds for the equipment were secured, but there were difficulties obtaining the 24 hour nursing cover that would be needed.

52. There was also discussion with HMP Doncaster about the possibility of their healthcare unit accommodating the man. This was in the event of

Moorland not completing the plans for a palliative care suite, or if an application for compassionate release was not agreed.

Compassionate Release

53. On 10 April, the acting governor began the compassionate release process for the man. An application form was emailed to the public protection and casework section (PPCS) of the National Offender Management Service (NOMS) on 12 April. The governor noted that he considered his case borderline, given his lack of acceptance of his offences. He also noted that a release address had not been secured. In addition, the governor noted he needed more information from the prison GP, who was on leave.

54. The prison administrator for the compassionate release process told the investigator that a conversation had been had with the PPCS before the application form was submitted. The prison was advised to send in the application early even though some information was missing and the Governor had some reservations.

55. However, the application was rejected immediately. A letter from the PPCS dated 15 April, said that as the Governor did not support the application it should have been rejected locally. The Governor was asked to keep the matter under review and re-contact them with a proper release plan once the man's risk was considered to have reduced.

56. On his return from leave on 22 April, the prison GP completed his part of the compassionate release forms and returned them to the offender management unit at the prison.

57. On 23 April, the revised compassionate release application was sent to the PPCS with a note that further GP reports were planned and that the Governor still considered it a borderline case. However, the Governor also made reference to the revised medical submission from the doctor, which commented on the likely decline in the man's physical condition and how this would limit his ability to commit further crimes. He died before a response was received.

58. The investigator asked the Head of Healthcare about contingency plans for completing compassionate release requests if a GP is away. She told the investigator that, although they have a prison GP, healthcare always has some GP cover every Monday to Friday. So, filling in the compassionate release form need not have waited for his return from leave. Because of the governor's concerns about the man and the lack of a release address, it is unlikely to have made a difference in this case. However, the delay was unnecessary and should be avoided in the future.

Palliative care plans and end of life pathway

59. 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 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. There are various examples of end of life care pathways.

60. The man died in hospital, but it is pleasing to see that the Head of Healthcare had contacted the local hospice to discuss a palliative care referral. The hospice indicated that they would be willing to review him if he was discharged to Moorland and offer support and training to staff. A palliative care referral form was completed with a view to completing it once more was known about his potential discharge from hospital. Sadly, he did not leave hospital.

Restraints, security and bedwatch

61. 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 and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.

62. 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.

63. The man was admitted to hospital on 5 April following tests that were carried out by the prison GP. It was not known what was wrong with him at this point although he was clearly very poorly. The risk assessment shows that he was considered a medium risk to the public and hospital staff and a low risk of escape. There is no healthcare information on the risk assessment apart from a comment that restraints may have to be removed for examination or treatment. He was restrained by way of an escort chain (a length of chain secured to the prisoner by handcuffs at one end and an escorting officer the other end). He was escorted by two officers.

64. On 8 April, when the man was told his diagnosis, the escort chain was removed.

65. On 11 April, the man was released on temporary licence and the escort was reduced to one. The acting governor told us that this was due to his level of confusion and the fact it was unlikely he would receive any visits from his family. There was also some concern that he may be at risk from some family members due to his offence.

66. Although it is pleasing to see that the restraints were removed on 8 April, we are not convinced that the initial risk assessment took into account the man's actual condition at the time and he was unnecessarily restrained when first taken to hospital.

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

1. The Governor should ensure that accurate next of kin records are maintained and a named family liaison officer is appointed as soon as someone is diagnosed with a serious or terminal illness, in line with PSI 64/2011.

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 & YOI Moorland

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that accurate next of kin records are maintained and a named family liaison officer is appointed as soon as someone is diagnosed with a serious or terminal illness, in line with PSI 64/2011.	Accepted	Next of kin details are being collated for every prisoner on reception to Moorland and recorded on NOMIS. Significant progress has been made in this area; according to the latest NOMIS Dashboard report only three next of kin details are outstanding. A key worker has been appointed and will liaise with Family Liaison Officers to ensure continuity of information and sharing of best practice to ensure appropriate standard and quality of life is maintained.	30.09.2013 Completed and ongoing	
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	Collators and Health Care staff have been made aware that individual risk assessments must contain relevant information regarding the health and ability of the prisoner which will have an impact on escape risk and subsequent level of restraints, prior to submission to the approving Governor. All risk assessments will be reviewed on a regular basis to ensure appropriate levels of restraints are used in line with the "Learning Lessons Bulletin" February 2013.	Completed and ongoing	