

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in May 2013 at
HMP Leyhill.**

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 from pancreatic cancer of a man at HMP Leyhill in May 2013. He was 67 years old. I offer my condolences to his family and friends.

A clinical reviewer carried out a review of the man's clinical care in custody. HMP Leyhill cooperated fully with this investigation.

The man first reported pain in his abdomen and left side in October 2012 when he was at HMP Shepton Mallet. A concerning lesion was identified later that month and after extensive investigation and tests he was formally diagnosed with pancreatic and stomach cancer in February 2013. In April 2013, following a short stay at HMP Erlestoke, he transferred to HMP Leyhill which has a palliative care suite.

Although it took the hospital some time to make a firm diagnosis, the investigation found that healthcare staff at Shepton Mallet referred the man quickly for tests when he first reported symptoms. Good efforts were made to help him re-establish contact with his family before his death. I am satisfied that, overall, he received good care at Leyhill and was treated with compassion and sensitivity.

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 received a life sentence in April 1994 for a number of serious offences. He had been at HMP Leyhill since 10 April after a brief stay at HMP Erlestoke. Before that he was at HMP Shepton Mallet, which closed in March 2013.
2. The man first reported pain in his abdomen and left side on 4 October 2012, when he was at Shepton Mallet. An ultrasound scan on 5 October did not reveal any major abnormalities. On 6 October, he was admitted to hospital, where a CT scan and blood tests revealed a massive lesion in the tail of his pancreas, but at the time it was unclear exactly what this represented.
3. Between October 2012 and February 2013 further tests were done including, blood tests, tumour markers, a CT scan, chest X-ray and an endoscopic ultrasound. On 14 February 2013, a specialist nurse from the hospital informed the prison that the man had cancer of the stomach and pancreas. He was told by prison healthcare staff the same day.
4. On 25 February, the man was admitted to hospital for rehydration and for a pain management plan to be drawn up. By the time he was able to leave hospital, Shepton Mallet was closing and he was discharged to HMP Erlestoke on 8 March.
5. It appears that there was some initial consideration of an application for compassionate release but this was not fully documented in the man's record. He later made it clear that he did not wish to apply for compassionate release. The records show that Erlestoke invited a local hospice to help assess his needs. The assessment concluded that his needs could not be met at Erlestoke. It is not clear whether a hospice place was considered at that time.
6. On 10 April, the man transferred to HMP Leyhill which has a palliative care suite. He initially lived on a standard prison wing and then moved to the palliative care suite on 25 April. Leyhill made good efforts to reconnect him with his family, with whom he had not been in contact for some time, and his sister and other family members were able to visit him several times before he died in May.
7. Although it took some time for the hospital to arrive at a firm diagnosis, we are satisfied that healthcare staff at Shepton Mallet referred him to hospital quickly when he reported concerning symptoms. Throughout his illness, prison staff dealt with the man compassionately and kept him fully informed about his condition and his treatment options. Leyhill contacted and informed his family when he felt ready to involve them. While it is not clear what initial consideration was given to compassionate release, we are satisfied that this was appropriately discussed with him at Leyhill. We are satisfied that overall he received good end of life care. We make no recommendations as a result of this investigation.

THE INVESTIGATION PROCESS

8. 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.
9. HMP Leyhill provided copies of the man's prison and prison medical records. Despite a number of requests, HMP Erlestoke did not supply additional information requested and the manager involved did not make himself available for the investigator to speak to him, contrary to Prison Service instructions about cooperation with Ombudsman's investigations.
10. A clinical reviewer reviewed the man's clinical care in prison.
11. HM Coroner for Avon was informed of the investigation and provided information about the cause of death. The Coroner has been sent this investigation report.
12. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose and scope of the investigation. She had no specific issues she wished the investigation to consider.
13. As part of the consultation process, the man's family was sent a copy of the draft report but they did not raise any significant issues resulting in any changes to this report. A copy of the draft was also shared with the prison. They raised one minor factual inaccuracy regarding healthcare's opening hours. This has been amended.
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 Leyhill

15. HMP Leyhill is an open prison near Bristol, which holds up to 527 male category D prisoners who require only minimum security.
16. The prison has a palliative care unit based on the design of a hospice in Bristol. It consists of two en-suite patient rooms and a family room for visiting relatives, plus a nurses' office. When occupied, the unit is staffed by prison healthcare staff during the working week and by local agency staff overnight and at weekends. Officers from B wing also work on the unit day and night when it is occupied
17. Health services are provided at the prison from 7.30am to 16.30pm on weekdays, with a GP out of hours service at other times. Primary care services at Leyhill are provided by Bristol Community Health and a local NHS Centre, Hanham Health, provide GP services.

Her Majesty's Inspectorate or Prisons

18. The most recent inspection of Leyhill was in April 2012. Inspectors found that a high standard of health care at the prison although there was some concern about the staffing mix and the disproportionate responsibility carried by healthcare support workers. Inspectors described the palliative care unit as a good initiative and found that an excellent palliative care service was provided. They were concerned about whether there would be funds to staff the unit out of hours.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent report, for the year ending January 2013, the IMB commented on the good service provided by healthcare staff. They added that the provision of palliative care facilities at the prison was likely to be of great benefit, but, like the Inspectorate, were concerned about how this would be staffed and funded out of hours.

Previous deaths at HMP Leyhill

20. The man is the fourth prisoner to die at HMP Leyhill of natural causes in the last two years. Two of the previous four men to die had been diagnosed with terminal cancer and on both occasions we found that they received a high standard of care and that staff at the prison acted professionally and with compassion.

ISSUES

The diagnosis of the man's terminal illness

21. On 4 October 2012, while at HMP Shepton Mallet, the man reported to prison nurses that he was experiencing abdominal pain. A prison GP arranged for him to have an ultrasound test at the Shepton Mallet NHS Treatment Centre on 5 October. No major abnormalities were detected apart from a slightly enlarged prostate. However, it was noted that his pancreas was partially obscured by overlying gases.
22. On 6 October, the man was admitted to hospital as this was the third day he had been suffering with left sided abdominal pain which had spread to his left flank. The hospital carried out blood tests and a computerised tomography (CT) scan, which creates detailed images of the inside of the body.
23. The man was discharged back to the prison on 10 October. On 24 October a consultant surgeon wrote to say that the CT scan had revealed a massive lesion in the tail of the man's pancreas and that this could be a neoplasm (abnormal mass of tissue which can become a tumour), pancreatitis (inflammation of the pancreas) or lymphoma (blood cancer). The prison was copied into the correspondence.
24. The man was referred to hospital for further tests and between 30 October and 25 January he underwent blood tests, which included tumour markers, a further CT scan, and was referred for an endoscopic ultrasound (where a tube with a camera is passed into the body to obtain a view of internal structures).
25. On 28 January 2013, the GP at Shepton Mallet saw the man and noted he was suffering from abdominal pain, weight loss, black stools and vomiting. He noted that he would try and get the results of the CT scan the man had had earlier in the month, as soon as possible.
26. On 1 February, the GP received the CT scan results, which showed a mass in an area affecting the pancreas, stomach and colon. He was aware that a multi-disciplinary team (MDT) meeting was being held at the hospital that day to discuss the results.
27. The man was admitted to hospital on 4 February for an endoscopy, stomach and chest X-ray. The endoscopy was carried out on 6 February. On 7 February, a member of the man's medical team at the hospital told a nurse at Shepton Mallet that they had discovered he had a large gastric ulcer which was bleeding.
28. On 10 February, the man was discharged back to Shepton Mallet. The discharge summary clarified the presence of a pancreatic tumour and also that a gastric ulcer had been found. He was discharged with opiate medication and tramadol (for pain control).

29. On 13 February, a multi-disciplinary team meeting at the hospital was held and the next day a specialist nurse at the hospital informed Shepton Mallet that the man had pancreatic and stomach cancer.
30. We are satisfied that the man was referred quickly to hospital for tests once he reported his symptoms. The clinical reviewer says that although it took several months of hospital tests to reach a firm diagnosis, there is nothing to suggest any inappropriate action which would have altered the outcome.

Informing the man about his condition and treatment

31. On 12 October 2012, one of Shepton Mallet's GPs discussed with the man the possible diagnoses of either cancer or pancreatitis. She noted that he seemed to accept this news and she felt he could cope with the uncertainty.
32. On 1 February 2013, another prison doctor saw the man. Since seeing the doctor the previous October, his health had deteriorated and he had undergone a number of investigative procedures at hospital. The GP discussed the CT scan results with him, his other symptoms and the likelihood that he had cancer. He said that he was relieved to know what was happening. He said that there was no one that he wished to inform.
33. On 14 February, when the diagnosis of pancreatic and stomach cancer was confirmed, a nurse from the Shepton Mallet healthcare team visited the man in his cell. She fully explained the diagnosis and how long he might be expected to live. She also explained the possibility of palliative chemotherapy, which he said he did not want. The nurse told him that hospital staff were meeting the next day to discuss his treatment options.
34. On 15 February, the nurse visited the man again and explained that the hospital team had concluded that he was not suitable for surgery but he would be offered an appointment to discuss palliative chemotherapy to alleviate symptoms. He firmly declined this option. On 18 February, the nurse spoke to him about his treatment options but he again declined to have any treatment. On 20 February, his care plan was updated to record that he did not wish to have palliative chemotherapy.
35. Subsequently, at Leyhill, a prison doctor, noted that the man seemed unaware of his prognosis. However, we are satisfied from the discussions documented at Shepton Mallet and Erlestoke that he had been fully informed and was aware of his diagnosis and prognosis and the treatment options available to him.

The man's medical appointments and treatment

36. The man had a number of appointments for scans and admissions to hospital before his diagnosis. Appointments were kept and actions following hospital attendances were appropriately managed by the healthcare team at Shepton Mallet. The primary care team kept in touch with the hospital about the timing and results of the investigations and tests. After his diagnosis, he declined further treatment so had no further hospital appointments.

The man's pain relief and medication

37. After he was discharged from hospital on 10 February the man was prescribed tramadol (for the relief of moderate to severe pain), morphine (an opiate pain killer) and omeprazole (to reduce stomach acid). On 27 February, Shepton Mallet arranged for him to be admitted to hospital so that a pain management programme could be arranged as he continued to have problems. He was also treated for dehydration.
38. The man left hospital on 8 March and went straight to Erlestoke. A nurse noted in his medical record that he was to keep his medication in his possession except zomorph, an opiod painkiller, which would be kept in the wing office. Oromorph (another opiod painkiller) would be delivered in 100ml bottles by healthcare staff for him to self-administer. She recorded that he was fully aware of how to take his medication and how to request advice about it.
39. On 12 April, two days after he had arrived at Leyhill, a nurse noted that he did not seem to be taking his oromorph or zomorph correctly. She spoke to him about this and discovered that he was taking oromorph more regularly, but then was falling asleep and forgetting to take the zomorph. She asked a prisoner designated as his wing carer to remind him to take his zomorph at 8.00am and at teatime. She noted that other nurses would check this three days later.
40. On 15 April, two nurses went to see the man to see how he was coping with his medication. Wing staff had had some concern that he might not have taken enough, but the nurses took stock of his medication and suggested that he might have taken too much. It was agreed that officers would keep his medication and prompt him to take it regularly and on time. The clinical reviewer notes that this was appropriate. On 19 April, staff from a hospice visited and reminded him that he should be taking 60mg oromorph when he got breakthrough pain which he had not been doing.
41. On 22 April, a clinical nurse specialist from the hospice wrote to a doctor at Leyhill to advise about the man's medication needs. Among other medications, such as amiltriptyline (an anti-depressant, also used as a pain killer), she asked the GP to start fentanyl patches (a very strong pain killer) as he seemed reluctant and forgetful about taking oromorph. She also requested an anticipatory prescription in case a syringe driver (which delivers medication automatically) was needed urgently.
42. On 25 April, the man was moved to Leyhill's palliative care unit. On 26 April, it was noted that he had experienced two episodes of pain during the night. An agency nurse had not realised that a higher dosage of oromorph should have been given for breakthrough pain. A syringe driver was set up that day.
43. We are satisfied that the man was prescribed appropriate pain relief. Although at first there appears to have been some problems with his ability to remember when and what to take this was resolved once officers began to remind him to take it. On one occasion an agency nurse in the palliative care unit was not fully aware of the correct dosage of oromorph for

breakthrough pain - apparently because there was a difference between the instructions on the medication label and the prescription. The Head of Healthcare told us that each time a new agency nurse comes on duty she gives them a thorough handover about administering medication but this incident suggests a need to reinforce their understanding.

44. 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.

Liaison with the man's family

45. When the man was given his diagnosis, a nurse at Shepton Mallet spoke to him about contacting his family. He made it clear that at that point there was no one he wished to contact.
46. When he arrived at Leyhill, the management plan for his care noted that the man had a sister who would need to be traced in case he was ever ready to contact her. Efforts to trace her began on 12 April. After some initial difficulties the prison's family liaison officer contacted the man's sister, who lived abroad, on 25 April. The next day, the man spoke to his sister by phone and the prison gave her a direct number for the palliative care suite. On 27 April, the man's sister and other family members visited him. He received two more visits from his family before he died.
47. The man's sister had returned home when he died, and the prison telephoned her with the news. A memorial service was held at the prison, and members of his family and a number of prisoners attended. The prison also made arrangements to inform other members of his family of his death and they attended his funeral as well as his sister and her family. Managers from the prison and other staff also attended. In line with national guidance, the prison offered assistance with funeral expenses.
48. We are satisfied that the prison made good efforts to ensure that the man's family were able to visit him before he died, in line with his wishes.

The man's location

49. As Shepton Mallet was in the process of closing when the man was admitted to hospital on 27 February, he was discharged to Erlestoke, where he lived on a standard prison wing. Another prisoner was assigned to help him with day to day tasks.
50. Staff from a hospice visited the man on 20 March to assess his needs. On 27 March a nurse specialist from the hospice wrote to the Governor of Erlestoke. He said that the man's healthcare needs would soon exceed what Erlestoke could provide in terms of nursing care. He said that the man would not have the physical capacity to abscond any distance. It is not clear from the records, or from the nurse's letter, whether the assessment was also for a place at the hospice.

51. Before the letter was received, the prison had identified that alternative accommodation was needed to meet the man's needs and on 26 March, the deputy governor requested a move to Leyhill as it has a palliative care suite. As Leyhill is an open prison, he needed to be re-categorised in order to move there. Despite repeated attempts, and the intervention of the Governor, the deputy governor did not respond to any of the investigator's requests for further information. Therefore we do not know whether the option of a move to a hospice was considered at that stage or whether Leyhill was considered as an alternative.
52. On 10 April, the man transferred to Leyhill, an open prison with its own palliative care unit. The formal agreement to re-categorise was dated two days later. Initially, he was allocated a room on a standard wing at Leyhill. Healthcare staff visited him on the wing and staff from the hospice assessed his needs. At the time it was noted that he was caring for himself, had a poor appetite and was suffering from some abdominal discomfort.
53. On 25 April, the man moved to Leyhill's palliative care unit after it was assessed he had only a few weeks left to live. He died in the palliative care unit in May.
54. It is unfortunate that we do not know whether a hospice bed at another hospice was a possible alternative location for the man, but we are satisfied that his transfer to Leyhill and subsequent move to the palliative care suite there, provided an appropriate location for his end of life care.

Compassionate Release

55. Early release on compassionate grounds (ECR) is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently 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).
56. On 15 February, a nurse at Shepton Mallet explained to the man that healthcare staff had raised the possibility of compassionate release with the prison, but he said that he had no feelings about the issue. There are some notes on his medical record later in February indicating that a compassionate release application was begun at this time but there is no other record to indicate that an application was made or whether this was discussed with him.
57. On 12 April 2013, at Leyhill, it was noted that the possibility of making an application for compassionate release had been discussed with the man but that he was not seeking this option. It is unfortunate that it is unclear whether there were any further discussions at Shepton Mallet or Erlestoke

about compassionate release, but we are satisfied that this was appropriately considered at Leyhill.

Palliative care plans and end of life care pathway

58. 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 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.
59. The man was fully consulted about palliative care and end of life plans. The hospitals, hospices and the prisons involved worked well together to ensure that he had an effective care. Healthcare staff implemented all relevant care plans alongside an end of life pathway.¹
60. The man was aware of his condition and prognosis and the records show that he was involved in and informed of his care plans. At first he did not want his family to be involved, but later agreed that they should be contacted and made aware of his position. The plans were followed and reviewed frequently. The clinical reviewer notes that palliative care plans were developed with the active involvement of him, and that hospice staff helped develop end of life plans. We are satisfied that there were appropriate plans for his end of life care.

Restraints and security

61. Prisons have 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. 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.
62. When the man was admitted to hospital from Shepton Mallet on 27 February 2013 he had been diagnosed with cancer. The risk assessment for his escort to hospital notes that he presented a 'normal' risk but the prison appropriately took into account his condition at the time. Notes clarify that he was unable to walk and too unwell to be able to escape. He was accompanied by one officer but no restraints were used. When he transferred to Leyhill he was not restrained.

¹ 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.

63. We are satisfied that the man's medical condition and how it affected his risk to the public were appropriately taken into account when assessing the level of security needed for escorts.