

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP and
YOI Parc in July 2013**

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 HMP Parc in July 2013. He died from lung cancer. He was 62 years old. I offer my condolences to his family and friends.

A clinical review was carried out on the standard of the man's clinical care at the prison. Staff at Parc cooperated fully with the investigation.

The man had been in prison for 18 months before he died. He had transferred from HMP Altcourse to Parc in September 2012. In November 2012, he told a doctor at Parc that he had a persistent cough. The doctor referred him immediately to the hospital. After a significant delay, he was diagnosed with lung cancer. His condition was terminal and only palliative treatment was possible. Just before his death, he said that he wanted to leave the hospital and return to Parc. He died at the prison two days later.

The clinical review has identified some issues of poor clinical governance at the hospital which are outside my remit, but I understand will be taken forward with the hospital by Healthcare Inspectorate Wales. In relation to the man's treatment at the prison, I am satisfied that he received a very good standard of care at Parc which was at least comparable to, and in some respects better than, that he could have expected to receive in the community.

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

January 2014

CONTENTS

Summary

The investigation process

HMP Parc

Issues

Recommendation

SUMMARY

1. The man was sent to HMP Altcourse in December 2011 and transferred to HMP Parc on 28 September 2012. At Altcourse, he had asked to see a doctor about a persistent cough but he did not attend the appointment. He did not mention the cough when he arrived at Parc. Just over three weeks later, he told a doctor about his cough and was immediately referred to hospital for a chest X-ray. This took place promptly on 21 November 2012, but subsequent tests, including further X-rays, were delayed.
2. The initial X-rays indicated abnormalities suggestive of lung cancer. The hospital reported that further investigations were needed, but a hospital specialist did not see the man until 24 January 2013, despite a further urgent referral from a doctor at Parc at the end of December. On 25 January, the GP at Parc sent him to hospital as his condition was deteriorating and no confirmed diagnosis had been made.
3. The man was discharged from hospital on 5 February without a diagnosis or treatment plan and without a full discharge summary to assist the GPs at Parc. On only one occasion during his illness and four related admissions to hospital was a full discharge summary was received.
4. On 8 February, the man was diagnosed with lung cancer. His condition was terminal and only palliative radiotherapy was possible as the cancer had spread. After the diagnosis, he was located on a small unit at Parc for older prisoners with increased health needs.
5. When the man was first admitted to hospital as an emergency, he was inappropriately held in restraints. However, the risk assessment was changed subsequently and restraints were not used during any of his later hospital admissions.
6. A family liaison officer, one of the prison's chaplains, kept in contact with the man's brother and supported him. He visited the man in hospital a number of times and helped him through a period of bereavement when his mother died at a point when he was very ill. The chaplain had sensitive discussions with him and his brother about his wishes in relation to his funeral.
7. The man was admitted to hospital towards the end of June, but wanted to return to Parc when he knew the end of his life was near. This was carefully planned to ensure that his needs would be met. He returned to Parc and died two days later.
8. HIW has identified the delay in diagnosis as a concern, but the prison acted appropriately. We are satisfied that the man received a good level of care at Parc and appropriate treatment after his diagnosis. We make one recommendation about medical appointments.

THE INVESTIGATION PROCESS

9. Notices were issued at Parc announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.
10. The Healthcare Inspectorate Wales (HIW) conducted a review of the man's clinical care at the prison and had all relevant documents to assist the review.
11. The investigator visited Parc on 28 August 2013 with a representative of HIW and jointly interviewed relevant healthcare staff including the general practitioner, the lead nurse and healthcare administrator. They also spoke to the deputy director, the Chair of the IMB and the family liaison officer. The investigator examined documents relating to the man's time in custody and visited the unit where he had spent most of his time during his illness. She spoke to his personal officer and his offender supervisor. She also talked to three prisoners who had been friends with him and lived on the same unit.
12. A copy of the investigation report has been sent to the local Coroner.
13. One of the Ombudsman's family liaison officers contacted the man's brother to explain the purpose of the investigation and invite him to raise matters he wished the investigation to consider. He said that his family had been very happy with the care provided by the prison and had no concerns.
14. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, family liaison, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP & YOI PARC

15. 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 sentenced. It also has a unit for around 60 young people under 18.
16. G4S provides 24 hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24 hour GP cover.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) last inspected Parc in July 2013. The prison was found to be safe and prisoners were well cared for overall. Efforts to help prisoners sustain relationships with their families and work with the families themselves were regarded as outstanding. The standard of health services was judged to be good and the new health care unit was described as impressive. There were some concerns about access to hospital health appointments as there were no systems to monitor waiting times.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to May 2013, the IMB reported that there had been significant improvement in the appointment management system for prisoners to see GPs. They pointed out that the number of deaths in custody reflected an increasing older population and noted the provision of special accommodation and facilities for them at Parc.

Previous deaths at Parc

19. The man was the eleventh prisoner to die at Parc since the beginning of 2012. Although several of these deaths were also due to cancer, we do not repeat any of the recommendations made following the investigations into those deaths. We have previously made recommendations about the use of restraints at Parc and we refer to this issue again in this report but make no recommendation.

ISSUES

The diagnosis of the man's terminal illness

20. The man was remanded in custody in December 2011. He was later sentenced to ten years and four months in prison for a sexual offence. He transferred to Parc from HMP Altcourse at the end of September 2012.
21. In June 2012, while at Altcourse, the man asked to see doctor about a persistent cough but did not attend his appointment. He saw a doctor when he arrived at Parc on 28 September 2012. He said that he was taking medication for pain in his foot but mentioned no other health concerns.
22. On 14 November, the man told a doctor at Parc that he had had a painful cough for two weeks. The doctor prescribed antibiotics and referred him immediately for a chest X-ray, which was completed at the hospital a week later.
23. On 3 December, Parc received the results of the X-rays, which indicated that there were abnormalities and that the man would be recalled for further investigations. However the hospital did not recall him. On 15 December, he told a prison GP that he had started to cough up blood. The GP treated him with antibiotics for a suspected lower respiratory tract infection and also made an urgent request to the hospital for the further investigations into possible lung cancer to be carried out. He was eventually recalled for further X-rays, which took place on 24 December, almost a month after abnormalities had been found. He saw a GP when he returned to Parc.
24. On 28 December, the man again saw a GP at Parc and complained of coughing up blood. The same day, the GP received the hospital report of the latest investigations which stated that other abnormalities had been found which were suggestive of lung cancer. The GP wrote to the hospital asking for urgent advice under the two week wait rule for suspected cancer. The consultant physician replied that he had arranged two appointments for him – one for the respiratory clinic and another for a scan of the thorax. The scan was carried out on 21 January and he was seen at the respiratory clinic on 24 January.
25. The man was due to return to hospital on 28 January for a bronchoscopy (a procedure which can help to diagnose and treat some conditions of the airways and lungs). However, his condition deteriorated and the GP at Parc sent him to hospital as an emergency on 25 January. The bronchoscopy was delayed as his oxygen levels were low and it was carried out on 4 February. He was discharged from hospital the next day. The discharge summary gave details of his medication but it did not contain a diagnosis, prognosis or treatment plan.
26. On 8 February, the GP at Parc spoke to the hospital registrar, who told him that cancer had been detected but it had not been possible to take a biopsy for a tissue diagnosis which was needed to determine an exact diagnosis and

the correct treatment. The man's condition was not curable and he was offered palliative treatment as the lung cancer had already spread. Three days later on 11 February, a full discharge summary was received at the prison by fax. This was 14 weeks after he first saw a doctor at Parc with a persistent cough. The diagnosis was formally confirmed on 28 February.

27. The clinical review has identified concerns about clinical governance at the hospital. In particular, that an urgent chest X-ray was requested on 14 November 2012, but that Parc did not receive the results until 3 December. HIW is also critical of the delay in the hospital seeing him after he was re-referred by the GP at Parc on 28 December and recommends that the provision of care to him at the hospital is treated as a serious incident. These are matters outside the remit of the Prisons and Probation Ombudsman. We are satisfied that the prison acted appropriately in referring him to specialist care when concerns were identified.

Informing the man about his condition and treatment

28. The man was seen by a doctor at Parc on 29 December 2012, the day after he had attended the hospital for chest X-rays. The doctor discussed the X-ray results with him, which indicated a possibility of cancer. He said that he had been expecting this to be case. On 5 February, after a hospital stay he told a nurse that he thought he had cancer but he had not been told this. The doctor at Parc spoke to the medical registrar at the hospital who said that the diagnosis could not be confirmed at that stage but he was not a candidate for surgery.
29. The first full discussion with the man about his diagnosis and treatment took place on 20 February. He told the doctor that he had decided that he wanted to receive any treatment available to him.
30. The man had a scan on 28 February which showed that the cancer had spread and a secondary growth (a metastasis) was found on his adrenal gland. That day, a hospital doctor discussed his prognosis with him and said that he had three to four months to live. The doctor explained that he was not fit enough for chemotherapy but that palliative radiotherapy could be offered, which he subsequently accepted.
31. The man had a number of discussions with the doctor about resuscitation in the even of a cardiac or respiratory arrest. He eventually decided that the medical team should make a clinical decision when the time came.
32. There was evidence of clear ongoing communication with the man about his illness and impending death. Although there was a delay in diagnosis, we are satisfied that he was told about his illness and treatment options by prison staff in a considerate and timely manner.

The man's medical appointments and treatment

33. The man had four admissions to hospital during his illness. HIW consider he was well cared for as an inpatient. While in hospital he had further tests, including an MRI scan, treatment for infections and several reviews by the palliative care team, but there was only one occasion when he was discharged with a full discharge summary. The lack of full discharge summaries from the hospital made it difficult for the healthcare staff at Parc to ensure that they were providing him with the best treatment while he was in their care.
34. A prison doctor saw the man on 6 February, the day after his discharge from a period of 12 days in hospital. As he had no discharge summary outlining the results of his recent investigatory procedures, which included a bronchoscopy, the doctor contacted a respiratory nurse at the hospital. They agreed that he would benefit from palliative oxygen which was then ordered.
35. On 9 February, the man had an assessment of his daily care needs at Parc. The assessment was updated frequently thereafter. As his illness progressed, nurses saw him on the unit every day and doctors also saw him frequently. On 15 March, he began a course of 12 palliative radiotherapy sessions at the Cancer Centre as an outpatient.
36. We are satisfied that the man was mostly able to attend hospital appointments for consultations, treatment and investigatory procedures as required. However, some appointments were rearranged because escorts were late or unavailable. Staff were unable to explain to us why he had missed an appointment on 14 January. HIW was satisfied that this did not adversely impact his overall care and treatment, but noted that there was confusion about how appointments were recorded in the medical record, how escorts were booked and whether it was recorded at all that a prisoner had attended the appointment. We note that HMIP also had concerns about access to hospital health appointments during their recent inspection. It is important for continuity of care that hospital appointments take place as scheduled. We make the following recommendation:

The Director and Head of Healthcare should ensure that medical appointments take place as planned by:

- **accurately noting the appointment in the medical record**
- **ensuring that there is an effective system for booking escorts**
- **accurately noting when an appointment takes place**
- **reviewing the reasons if an appointment fails**

The man's pain relief and medication

37. The man first mentioned experiencing pain after he left hospital on 5 February. He was discharged with a salbutamol inhaler and prednisolone (a steroid tablet to assist breathing). Paracetamol was prescribed for pain relief.

38. On 26 February, the man asked to see the GP at Parc because his pain had increased. The next day, the GP diagnosed a lower respiratory tract infection and prescribed an antibiotic.
39. On 21 March, the man told the doctor he was experiencing chest pain and coughing up blood. The doctor arranged for an emergency hospital admission and a respiratory medicine consultant reviewed him. When he returned to the prison the next day, he was prescribed dihydrocodeine, a stronger painkiller.
40. On 9 April, the man complained of pain on the left side of his chest after completing his radiotherapy. The doctor added naproxen (an anti-inflammatory drug) to his medication. On 15 April, the doctor added clarithromycin (an antibiotic) as the pain had not improved.
41. On 1 May, the man told the doctor that he was not in pain, but two days later he said that he was experiencing pain around his liver area. He was wheezy and had pain when he moved and coughed. On a scale of one to ten (ten being highest), he said that the pain was a level seven. He was given a laxative and the dihydrocodeine was changed to tramadol (another painkiller) and an ECG and blood tests were arranged.
42. The man was reviewed by the doctor four days later. His pain had not improved and he still had a persistent cough. The doctor changed his medication to MST and oramorph (both opioid painkillers) and cyclizine (an anti-emetic to help with the nausea sometimes caused by the introduction of morphine).
43. The man's level of pain fluctuated over the next few days and the MST was increased. He did not improve and, on 15 May, the doctor made an urgent referral to the palliative care team at the hospital. The next day he complained of pain in his arms and legs and was admitted to hospital, where an MRI scan showed secondary cancerous growths on his spine.
44. The man saw the palliative care team and had an appointment for the Cancer Centre on 17 May for more radiotherapy on his spine. He was in great pain during the journey to the centre and was advised to have extra morphine before the next trip.
45. The man had two poor days on 23 and 24 May with pain and vomiting. On 25 May, the doctor was concerned that he might have pneumonia and arranged for his immediate admission to hospital. He was given a seven day course of antibiotics for a chest infection. He saw the palliative care team twice. He was discharged on 3 June without a discharge summary and restarted his medication on his return to Parc.
46. On 13 June, he told the doctor at Parc that his pain was well controlled and that he felt okay. On his final admission to hospital on 25 June, the man complained of pain in his hip. His pain control medication was immediately adjusted and he had an X-ray of the hip followed by a review by an

orthopaedic team. The pain eventually settled and was thought to be asymptomatic. When he left hospital, his pain was well controlled.

47. The man had increasing pain as his illness developed and the cancer spread but we are satisfied that pain relief was prescribed without delay and reviewed and changed when it appeared not to be effective.

Liaison with the man's family

48. The man's next of kin was his brother. They had stayed in touch sporadically, mainly by telephone, during his time at Parc. His brother was kept fully informed of developments relating to his brother's illness, including hospital admissions and related care and treatment, usually by the family liaison officer. A family liaison log was opened on 8 March 2013. There was telephone contact at least weekly with his brother, who was given the direct line for the chaplaincy department and told that he could telephone any time for information or support.
49. The prison's family liaison officer discussed funeral arrangements with the man and his brother before his death. They also agreed how Parc would notify his brother when he died. As agreed, the family liaison officer telephoned his brother within twenty minutes to notify him of his death. He thanked prison staff for the good level of care given to his brother as well as the contribution that was given towards funeral expenses.
50. We are satisfied that there was a good level of communication with the man's next of kin.

The man's location

51. When his condition deteriorated, the man was transferred from a standard residential unit to a unit dedicated for older prisoners with increased health needs. This ensured that he received a high level of input from staff and support from his peers. His cell had en-suite facilities and handrails. He was also provided with a hospital bed and a special mattress when he became immobile. Staff we interviewed spoke knowledgeably and compassionately about him.
52. During the man's final days, his cell door was not locked so that staff could check on him easily and other prisoners visited him often. Three prisoners we spoke to who knew him well, all said that he was provided with excellent care by healthcare staff and prison officers. They said that he had wanted to die at Parc with his friends nearby and being cared for by staff who knew him. He had written a poem about his impending death which was laminated and displayed on the unit.
53. We are satisfied that the man was accommodated according to his wishes and with appropriate facilities to meet his needs.

Compassionate release

54. 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. 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 is granted by the Secretary of State only in exceptional circumstances.
55. Prison records indicated that an application for the man's early release on compassionate grounds was made on 18 February 2013. His offender manager at Parc told us that the application had been made while she was on leave. When she returned, she was told that the application had been made without his knowledge to avoid getting his hopes up, as it was unlikely to be granted. However, he told staff that he did not want to be released early as he did not want to be a burden on his brother and niece and did he want to return to his home area.
56. On 30 May, the Director received a letter rejecting the application as none of the four aspects of the criteria outlined above were met. There is no record that the man was informed of the application or the outcome but we are satisfied that compassionate release was given appropriate consideration.

Palliative care plans

57. A palliative care pathway was started for the man at the end of February and followed both at Parc and at the hospital, where a nurse explained the palliative care policy to him. He was seen daily by the palliative care team in hospital and there was ongoing communication between the hospital and the healthcare team at Parc as his condition deteriorated.
58. On 24 June, a GP reviewed the man's condition and noted significant deterioration. The GP offered to transfer him to another facility but he said that he would be happier to stay at Parc. During that night he continued to weaken, he could not stand unaided and was incontinent of faeces. He was admitted to hospital the following day and was reviewed by the palliative care team. Over the next few days he was treated for an infection and dehydration and his pain relief was adjusted.
59. There were two full palliative care reviews on 3 and 8 July. The man was clear that he wanted to be nursed by healthcare staff at Parc at the end of his life. Detailed planning to bring him back to Parc for terminal and palliative care then began.
60. A 24 hour nursing rota was arranged as well as twice daily reviews by a GP. Healthcare staff purchased a syringe driver (a small infusion pump used to gradually administer small amounts of medication) to administer morphine,

received refresher training on how to use it and ordered the appropriate drugs. In the event the syringe driver was not needed.

61. On 15 July, staff from Parc visited the man in hospital. When he returned to Parc the next day, the doctor noted that he was comfortable, pain free and sleeping much of the time. Over the next two days, staff noted that he was easily tired but not complaining of pain.
62. The man died peacefully. The doctor noted 'he needed no further medication in the night and he died in the comfortable position that I saw him in yesterday evening'.

Restraints, security and bed watch

63. 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.
64. 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.
65. The man was first admitted to hospital as an emergency on 25 January after he complained of shortness of breath. He stayed in hospital for 11 days. His risk assessment indicated that he was medium risk of escape and harm to the public. The authorising manager decided that he should be restrained using an escort chain and be accompanied by two officers.
66. Daily management visits were carried out and the man's risk was reassessed at each of these visits. The level of restraints remained unchanged. While he was in hospital, records completed by prison escorts confirmed that he was fully compliant and spent a lot of time asleep. The specific reason given for the use of an escort chain was recorded in the initial assessment as 'escort chain due to ambulance' and subsequently as 'serving offender cat B'. We do not believe that the risk assessments took full account of the individual risk that he presented and was inadequate to justify the use of restraints.
67. We discussed the use of restraints with the Director of Parc. She explained that the procedures for completing risk assessments had been revised since the man was inappropriately restrained during his first hospital stay.

Healthcare staff are now required to have greater input into the risk assessments and to comment on the health of the prisoner and how this affects the risk and the use of restraints, not simply to state whether there are any medical objections to the use of restraints. This was evidenced in subsequent risk assessments that we examined which confirmed that restraints were not applied for any of his subsequent hospital appointments or inpatient stays. On most occasions, he was escorted by a single officer. Although the original use of restraints appears not to have been justified, we are satisfied that procedural changes meant this was not repeated for future admissions and therefore make no recommendation.

RECOMMENDATION

The Director and Head of Healthcare should ensure that medical appointments take place as planned by:

- accurately noting the appointment in the medical record
- ensuring that there is an effective system for booking escorts
- accurately noting when an appointment takes place
- reviewing the reasons if an appointment fails

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Director and Head of Healthcare should ensure that medical appointments take place as planned by:</p> <ul style="list-style-type: none"> • accurately noting the appointment in the medical record • ensuring that there is an effective system for booking escorts • accurately noting when an appointment takes place • reviewing the reasons if an appointment fails 	Accepted	<p>An entry is now made by Admin on the electronic patient records of all patients who are due to attend internal and external medical appointments. Application forms are returned to prisoners with details of the forthcoming appointment when they request an internal appointment via the application process.</p> <p>A robust system has been introduced to ensure that a set number of external hospital escorts are planned in advance. Cancellations will only be made in extreme circumstances and only on the authority of the Duty Director.</p> <p>Admin now liaises with Security to check that patients have attended external hospital appointments. Reasons for non-attendance are recorded and discussed at the newly implemented monthly Operational/Healthcare meetings.</p>	<p>Completed and ongoing</p> <p>Healthcare Practice Manager</p>	