

**Investigation into the death of a man at  
Queen Alexandra Hospital, Portsmouth,  
in July 2012, while a prisoner at HMP Kingston**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**April 2013**

This is the report of the investigation into the death of a man who died in hospital in July 2012, while he was a prisoner at HMP Kingston. He had been diagnosed with inoperable lung cancer just the week before. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer undertook a review of the clinical care the man received at Kingston. Kingston cooperated fully with the investigation.

The investigation found that the man did not receive a good standard of care equivalent to that he might have expected in the community. During the six months leading to his death, he complained of pains in his left arm, shoulder, chest and back. He also had a persistent cough and breathlessness. The man had a long standing injury to one of the nerves in his left arm and this might have misled healthcare staff who examined him. However, poor processes in the healthcare department at Kingston also seem to have contributed to his illness not being diagnosed sooner.

A prison doctor first suggested that the man might have lung cancer in March 2012. System failures, compounded by poor handling of a referral for an X-ray and insufficient analysis by a hospital specialist, meant that the diagnosis of cancer was not seriously considered again until June. By this time, the man had an inoperable tumour on his left lung, which had also spread to the right lung. He was admitted to hospital on 25 June, where his condition deteriorated much more quickly than anticipated and he died just over a week later. The man was restrained by the use of an escort chain until just an hour before his death.

This investigation has indicated a need for improvements in healthcare systems and processes at Kingston to ensure prisoners receive an appropriate standard of care. I am also not persuaded that the use of restraints, almost up until the man died, was fully justified by considered risk assessments which took into account his terminal condition and appropriately balanced security with humanity.

The man's son considered the report at the draft stage and this final version reflects his concerns about the care his father received. The report also includes further information provided by the healthcare providers, and the National Offender Management Service (NOMS) response to the recommendations made.

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**

**April 2013**

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## SUMMARY

1. In 2002, the man was imprisoned for serious offences and was first taken to HMP Manchester. He told healthcare staff that he had a long standing injury to the nerve in his left arm for which he took pain relief medication. He continued to be prescribed medication in prison and was referred for physiotherapy.
2. The man transferred to HMP Kingston in July 2010. Healthcare staff noted his existing health problems and that he smoked between 20 and 40 cigarettes each day. In February 2011, he began to try to give up smoking.
3. In December 2011, the man complained of pain in his upper left arm and was prescribed additional pain relief medication. He continued to experience pain over the following weeks and saw another doctor. He was prescribed various medications in an attempt to manage the pain.
4. By February 2012, the man complained of a cough and pain in his left shoulder and back. The doctor who examined him was not sure what was causing the symptoms but recorded that he would do further research and review the man again. In March, the same doctor noted that the man might have lung cancer and should have a chest X-ray. On 20 March, the man's shoulder was X-rayed, after a referral by the nurse practitioner to explore his ongoing back and shoulder pains. This referral was unrelated to the doctor's suggestion that the man have a chest X-ray. The hospital consultant who reviewed the X-ray concluded that it was normal. No one in the prison healthcare department identified that the suggested chest X-ray had not been performed.
5. In early June, the man reported chest pains and breathlessness, which he said he had been experiencing for several months. His heart was checked and was normal. The man was diagnosed with acid reflux and prescribed medication. On 18 June, a prison doctor who examined him considered that his symptoms were highly suggestive of lung cancer. The man was referred to the hospital for further tests and an X-ray appointment was booked for 25 June. Until then, he was seen most days by healthcare staff because of his cough and breathlessness. On one occasion, a doctor diagnosed a chest infection and prescribed antibiotics.
6. The man had a chest X-ray at hospital on 25 June and was admitted as an inpatient that day. On 27 June, he was told that he had inoperable lung cancer and that he might live for up to 12 months if he received chemotherapy and radiotherapy and two months if he did not. However, the man's health deteriorated much more quickly than anticipated and he died the following week at 8.30am in July.
7. This investigation has found that the man did not receive an appropriate standard of clinical care. We have identified some healthcare staffing issues at Kingston and a need for improvement in some healthcare systems, including the implementation of formal end of life care plans. We are also critical of the decision to apply restraints to the man, despite his condition, almost until his death. We make eight recommendations as a result.

## THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on the day of his death. The investigator issued notices to both staff and prisoners at HMP Kingston to inform them of the investigation and asking anyone with relevant information to contact her. No responses were received.
9. The investigator visited HMP Kingston on 12 July and met members of the prison management team, the appointed family liaison officer and staff based on the man's wing. She also interviewed three prisoners who knew the man. The investigator obtained copies of the man's medical record and relevant aspects of his prison records.
10. A clinical reviewer was appointed to review the clinical care the man received at Kingston. The clinical reviewer was also given a copy of the man's medical record.
11. The clinical reviewer and the investigator returned to Kingston in August and September to conduct interviews with staff. The investigator gave the Governor verbal and written feedback following the interviews. She also spoke to the man's solicitor by telephone.
12. HM Coroner for Portsmouth and South East Hampshire was informed of the investigation and provided the results of the post mortem investigation. The Coroner will be sent a copy of this report to assist with his enquiries.
13. One of the Ombudsman's family liaison officers contacted the man's son outlining the purpose of the investigation. The man's son was concerned that, despite his father having complained of pain for some time, his cancer was not diagnosed sooner. He said that it had taken some days to inform him of his father's death and asked why it had taken so long. The man's son provided us with documents from the man's belongings which supported some of his concerns and helped to inform the investigation.
14. The man's son considered the report at the draft stage. He continues to have serious concerns about the care the man received at Kingston. His primary concern is the standard of clinical care his father received in prison, and the consequent delay in diagnosing his lung cancer. He remains upset that he and his father were not able to spend time together before his death. The man's son is also concerned about the use of restraints while the man was in hospital, and a possible failure to ensure that he was being provided with food when he was too unwell to get it himself. The man's son believes that his father's rapid deterioration and sudden death could have been avoided had he received clinical care of the same level and accessibility as that provided in the community.
15. The man's son is disappointed with the prison's delay in contacting him after his father died, and does not accept that reasonable steps were taken to obtain his contact details. He is also concerned that some items of his father's possessions were not returned to him until some three months after he died. He believes he

has still not been provided with all of his father's possessions and that other items remain at the prison or have otherwise been disposed of.

16. 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 KINGSTON**

17. HMP Kingston is in Portsmouth, Hampshire and holds up to 205 life sentenced and other indeterminate sentenced adult male prisoners. (This means that release can only be agreed once the prisoner has served a minimum term set by the court and the Parole Board agrees he is no longer a risk to the public.) In 2011, Kingston reduced its security category from B to C which means it holds medium risk prisoners requiring lower levels of security but not yet suitable for open conditions and who do not have the resources and will to escape.
18. Healthcare at the prison is provided by Solent NHS Trust. A nurse is on site from 8.00am to 6.00pm daily. A visiting GP attends three times a week and specialists in mental health, dentistry, optometry, physiotherapy and podiatry attend regularly. An out of hours GP service provides cover in the evenings and at weekends.
19. Nurses at Kingston are able to assess and triage patients in the absence of a GP, and are able to issue over the counter medication such as paracetamol and ibuprofen. In addition to the GP clinics, a modern matron (a qualified nurse practitioner) runs clinics. Prisoners needing secondary care, laboratory investigations and emergency admissions are generally referred to Queen Alexandra Hospital in Portsmouth.
20. In February 2012, a previous modern matron and other senior members of healthcare staff at the time were suspended, pending an investigation. The current modern matron was asked to fill the vacancy temporarily before taking up the position permanently in June 2012.

## **HM Inspectorate of Prisons (HMIP)**

21. HMIP last carried out a full inspection at Kingston in August 2010 and reported that the prison was a safe and decent place. Relationships between prisoners and staff were described as mutually respectful. An impressive level of staff engagement with and support for prisoners was identified and the personal officer scheme was found to be working well.
22. Health services were described as much improved since the previous inspection. Generally, prisoners said that they found it easy to access health professionals and 58 percent of those surveyed said that the quality of health services at Kingston was good which was much higher than the comparator with other prisons of the same category.
23. The Inspectorate reported that the prison used the Solent palliative and end of life care pathway for terminally ill prisoners and that healthcare staff worked with local hospices in providing care and training.

## **Independent Monitoring Board (IMB)**

24. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper

standards of care and decency are maintained. The most recent IMB annual report for Kingston covers the year 2010/2011.

25. The IMB reported that Kingston was a decent prison. They reported that, generally, prisoners spoke well of the health services at Kingston. The Board described healthcare provision as excellent.

### **Previous deaths at Kingston**

26. The man is the fourth prisoner to die of natural causes at Kingston since December 2009. Although there are no particular similarities between the circumstances of the deaths, three of the recommendations we make here are similar to those we have made in previous cases. In 2012, we highlighted the need for a local healthcare investigation following a serious incident, such as a death in custody. In 2011, we recommended that the processes for ensuring that two week rule referral letters be sent were tightened. We were also critical of the risk assessment process which guides the use of restraints on prisoners in hospital.

## ISSUES

### The diagnosis of the man's terminal illness

27. The man was convicted in January 2002 and was given an indeterminate sentence for public protection. When he first arrived in prison, he reported that he had injured the ulnar nerve (which runs from the shoulder to the fingers) in his left arm some years earlier. He was already prescribed amitriptyline (to treat nerve pain) and over the following years, he was prescribed a variety of different medications to manage the pain and he had appointments with physiotherapists.
28. On 26 July 2010, the man transferred to Kingston. He had a routine health screen shortly after he arrived. The man said that he smoked cigarettes (later recorded as between 20 and 40 per day) and did not want to stop. His long term problem with his ulnar nerve was recorded. The man's blood pressure was 130/80 mm/Hg (very slightly higher than normal), his pulse was 74 (a normal reading) and he weighed 81.55 kilograms (kg). In February 2011, the man decided to try to stop smoking and was prescribed medication to help. In December, he tried nicotine replacement patches instead.
29. On 14 December, the man saw one of the prison doctors, Dr A, and said that the nerve running to his left armpit had been painful for about three months. A hand written account by the man (which was passed to us after his death by his son) indicates that he thought he had further injured his arm while working in the grounds at Kingston. The doctor prescribed naproxen, an anti-inflammatory medication.
30. Three weeks later, on 9 January 2012, the man was examined by another prison doctor, Dr B, who thought the man might have a trapped nerve in his neck, causing pain in his arm, shoulder and neck. The doctor said that he could not remember the man mentioning a cough or any chest symptoms during the appointment. The doctor prescribed etodolac (another anti-inflammatory medication) to help manage the man's nerve pain but two weeks later, the man complained that etodolac made him feel "funny" and he was re-prescribed naproxen.
31. Healthcare assistant (HCA) A spoke to the man on 16 February and recorded that he was unhappy about the medical care at Kingston and wanted to see a doctor. (As explained earlier, there were some personnel changes in the management of the healthcare department at about this time.) The man told the HCA that the nerve pain was travelling to his shoulder and down his back. The HCA took his pulse and blood pressure, both of which were within the normal ranges and weighed him. The man now weighed 83.9kg.
32. On 22 February, Dr C, a doctor and clinical director for Solent NHS Trust, examined the man. He noted that the man had been experiencing pain in his upper arm for about three months and that naproxen was not helping. The doctor wrote that the man also had a cough, which had begun at the same time as the upper arm pain. This was the first record of the man having a cough. The man said that he was not coughing up blood or sputum and did not have any

pain when he breathed. The doctor recorded that the man was a non-smoker (although he was still using nicotine replacement patches) with no history of lung disease or asthma. The man was gaining weight, had no problems with his appetite and was not wheezing. The doctor listened to the man's chest which sounded normal. The doctor wrote that he was not sure what was causing the man's problems and that he would carry out some research into the symptoms and review the man in a week.

33. Dr C told the clinical reviewer that he completed two clinics at Kingston, one in February and one in March 2012. He explained that, although he was not certain what was causing the man's symptoms, he thought they might be the result of a lung tumour irritating the nerves to the arm.
34. The man saw the modern matron on 5 March, still complaining of pain in his arm and shoulder. (The modern matron fulfils the role of Head of Healthcare at Kingston.) The man said that he felt he had been "fobbed off" by other healthcare staff and that none of the medication he had been prescribed had helped relieve the pain. The modern matron examined the man and noted that his shoulders were not symmetrical, with the left shoulder appearing lopsided. The man was unable to move his arm as fully as normal and complained of pains. The modern matron prescribed nefopam, a pain relief medication, and referred the man to the physiotherapy team. He also referred the man for a left elbow and shoulder X-ray.
35. On 7 March, the man told HCA A that he planned to make a complaint and speak to his solicitor about what he perceived to be a lack of treatment for his arm and shoulder pain. The following day, the modern matron reviewed the man's condition and recorded that nefopam was helping to manage the pain and that the man might find acupuncture helpful. The modern matron wrote that he would try to give the man a session of acupuncture the following week. He also noted that he would try to arrange for the physiotherapist to assess the man earlier than the next planned clinic.
36. Dr C made an entry in the man's medical records on 13 March (he did not actually examine the man on this occasion), noting that he had informally discussed the man's symptoms with a specialist who thought that they could be caused by one of a number of health problems, including a pancoast tumour (a specific type of lung cancer). The doctor noted that the man should be referred for a chest X-ray and that, if possible, he wanted to review the man personally after that had been done. The doctor told the clinical reviewer that he did not complete the X-ray referral himself as he did not know where the correct form was kept at the prison. The doctor acknowledged that he had not arranged a handover at the end of the clinic of the cases requiring further review or investigation.
37. In an updated statement provided to the clinical reviewer after the draft report had been issued, Dr C said that he remembered discussing the man and the specialist's advice with the modern matron. The doctor said that he asked the modern matron to ensure the man was booked for a review appointment with a doctor. The doctor said that he could not remember whether he asked the

modern matron to order a chest X-ray. The man was not referred for a chest X-ray at this time.

38. The man's son gave us a copy of a complaint that the man submitted to the prison on 16 March. In it, the man expressed his frustration that he had still not been given a diagnosis to explain his arm, shoulder and chest pain. He described "climbing the wall in agony". The modern matron responded on 6 April, noting that the physiotherapist thought the man's problems were caused by muscles pressing on nerves. He advised the man to continue to take his prescribed medication and assured him that errors which had occurred under the previous modern matron would not be repeated. At around the same time, it seems that the man also approached several law firms seeking help with a clinical negligence claim, but this had not progressed by the time of his death.
39. On 20 March, the man went to hospital for his shoulder X-ray. Dr C said that he was not aware that the man's chest had not been X-rayed because he did not do another clinical session at Kingston at the time and the man was reviewed by other doctors.
40. Dr B reviewed the man on 26 March and wrote that the chest X-ray results had not yet been received (it seems he did not realise that the chest X-ray had not been requested or, therefore, performed). The doctor recorded that he believed the man was suffering with trapped nerves at the top of his spine and that he should be referred to the hospital orthopaedic department for further exploration. According to an entry in the man's record, the referral was made by the healthcare department administrator on 30 March, but there is no copy of the actual referral form in the man's record.
41. The results of the shoulder X-ray were filed in the man's medical record at some point on 26 March. The hospital consultant radiologist who analysed the images concluded that there were no abnormalities. There is nothing to indicate that the results were reviewed by anyone at Kingston. None of the healthcare staff interviewed realised that the chest X-ray suggested by Dr C had not been carried out.
42. The man was reviewed by the physiotherapist on 4 April and by the modern matron on 10 April. According to the entries made in the medical record, both appointments focused on the man's pain and there was no mention of him having a cough.
43. On 18 April, the hospital orthopaedic department wrote to the prison in relation to the referral made on 30 March and asked them to re-direct the referral to the low back care pathway team. Because the original referral was not available, it has not been possible to establish why the hospital thought the referral had been wrongly directed. All the entries in his medical record indicate that the man was suffering with upper back problems. The hospital letter was scanned onto the man's record on 18 April, but there is no evidence that it was reviewed or questioned by any member of healthcare staff until 20 June, when the department administrator chased up the referral and logged that it had been rejected.

44. The modern matron examined the man again on 6 June. The man complained of chest pains and said he felt breathless, but had done so for several months. He said that both symptoms worsened when he was lying down or when he ate. He said that he had been vomiting a clear liquid. The modern matron carried out an electrocardiogram (ECG – a test which measures the electrical output of the heart and highlights irregularities or problems). The results showed that the man's heart was beating fast but was otherwise normal. In interview, the modern matron said that it could be difficult to diagnose the man's problems because he was not always consistent about how he described his symptoms. When pressed for detail about his current problems, the man described having difficulty catching his breath as a result of indigestion like pains, rather than being short of breath. The modern matron concluded that the man was suffering with acid reflux (a common problem when stomach acid leaks into the gullet) and prescribed indigestion medication. The man's blood pressure remained in the normal range, however, he had lost some weight and now weighed 78.8kg.
45. Three days later, on 9 June, Nurse A examined the man in his cell after officers were concerned about him. The nurse recorded that the man had pain in his left side and lower left chest and had coughed continuously during the night. The nurse noted that his breathing rate was higher than normal and he was coughing a lot. The man's blood pressure reading was 120/96 mmHg (slightly higher than normal) and his blood oxygen level was 97 percent (within the normal range). When interviewed, the nurse said that she found it difficult to get a clear history from the man. However, she said that she was satisfied that he was not coughing up blood and did not think that he had a chest infection. She listened to his chest with a stethoscope and recorded that the air entry sounded harsh, which she thought was the result of the mucus-like substance he was coughing up.
46. The man told the nurse that the chest pains and cough were the result of his prescribed pain relief medication. Nurse A said he was focussed on resolving his arm pain and reluctant to discuss any respiratory problems. After examining him, the nurse gave the man advice on deep breathing and relieving the pain of coughing and recorded that she would return to see him the following day. She did so the next morning and the man said that he was coughing less and feeling a little better, although he still had pain down his left side.
47. The lead physiotherapist reviewed the man on 12 June and recorded that there was no apparent musculoskeletal explanation for his symptoms. He concluded that the man needed a medical review.
48. At around 9.00am on 18 June, one of the prison doctors, Dr D, examined the man. The doctor noted the man's symptoms of pain across his shoulder and upper chest and a persistent cough. She also wrote that the man had lost weight (he now weighed 75kg), was short of breath and had tender muscles from coughing. She wrote that, in her view, the symptoms were suspicious and that the man might have cancer, perhaps of the respiratory tract, which was affecting the nerves in his arm and causing pain. She noted that the man should be urgently referred to Queen Alexandra Hospital under the two week rule and that

he should undergo a chest X-ray and further tests. (According to National Health Service guidance, when a doctor suspects that their patient might have cancer, the patient should be seen by a specialist within two weeks of the referral.)

49. Dr D told the clinical reviewer that she felt it was clear that the man had lung cancer. He was breathless and coughing and she noticed deformities to his fingernails which were highly suggestive of lung problems. She explained that she wanted to make a two week referral but could not find the necessary form in the consulting room. The doctor said the modern matron told her he would make the referral but as she thought it was very important that the man be seen urgently, she wrote a referral letter by hand indicating that she thought he had lung cancer, and left the letter on the desk for the nurses to take to the administrator for processing. There is no evidence of either the doctor's letter or any other two week rule referral in the man's medical record. The hospital replied on 21 June, giving the man a routine X-ray appointment on 25 June. The clinical reviewer notes that, although there is no evidence of a two week referral having been made, the man was in fact seen well within two weeks.
50. On 22 June, a nurse consultant for Solent NHS Trust was running a clinic in the prison and was asked to see the man in his cell because he was short of breath. The man said that his arm was hurting and he had not slept well. The nurse noted that the man had a chronic cough and was coughing up clear sputum. He recorded that, in his view, the man might have an upper respiratory tract infection and perhaps chronic obstructive pulmonary disease (COPD – a congestive lung condition). The nurse treated the man with salbutamol (normally prescribed to asthma sufferers) through a nebuliser (which distributes medication in a mist through a face mask). The nurse instructed healthcare staff to monitor the man over the weekend. The man's blood oxygen level was 95 percent (and still within the normal range). In the medical record entry, the nurse made no reference to Dr D's assessment on 18 June or Dr C's earlier view that the man might have lung cancer.
51. The following morning, Saturday 23 June, the man went to the healthcare unit, complaining of further shortness of breath and difficulty breathing. Nurse B recorded that he was very animated and that she had advised him to calm down. He was given more medication through a nebuliser and the out of hours GP service was telephoned. The man's blood oxygen level was still 95 percent. A doctor from the out of hours service examined the man later that morning and concluded that he had a chest infection. He was prescribed antibiotics.
52. At 9.15am the next morning, Sunday 24 June, the man went to the healthcare unit still having difficulty breathing. Nurse B wrote that the man was again very animated and asked for medication through the nebuliser, which she concluded was not necessary at the time. She took the man's vital readings which were within the normal ranges.
53. Three quarters of an hour later, an officer asked Nurse C to examine the man in his cell because he was breathless and coughing. The nurse took the man to the healthcare unit and placed him on the nebuliser. After this, his blood oxygen level was 96 percent. While we are concerned that nurses apparently failed to

recognise the severity of the man's condition, particularly in the light of Dr D's recorded concerns, we accept that they were likely to be reassured by the out of hours doctor's conclusion that the man had a chest infection. It seems they were also misled because the man did not appear to be very ill as he had a good skin colour and was speaking normally.

54. At 1.00am on 25 June, Senior Officer (SO) A, the prison's night manager, spoke to the man who was coughing, wheezing, complaining of breathlessness and asking that an ambulance be called. The SO told the investigator that he and Officer A (who is a first aid instructor at the prison) went to the man's cell. The SO said that he had seen the man several times over the preceding weeks and did not think that he seemed any more seriously unwell than previously. He said he offered to call the out of hours GP service for the man, but he did not want this. The SO said that he instructed night staff to check the man at half hourly intervals, which they did. According to the SO, the man fell asleep shortly after he spoke to them. The SO told the investigator that he would not delay calling an ambulance if he had serious concerns about a prisoner's health.
55. In the morning the man went to the healthcare unit and was placed on the nebuliser. He told Nurse A that he had not slept for four days because he felt so breathless.
56. Later on 25 June, the man went to Queen Alexandra Hospital for the booked chest X-ray. That afternoon, hospital staff confirmed that the results had revealed abnormalities in the man's left lung and he was admitted to hospital for further tests. According to the log completed by officers with him in hospital, at 11.15am on 27 June, a hospital doctor told the man that he had a cancerous tumour in his left lung, which had also spread to the right lung and was inoperable. The hospital doctor told the modern matron that the X-ray carried out in March, although focused on his shoulder, had not been completely normal and had showed a problem with the man's lung.
57. The clinical reviewer identifies a number of ways in which the treatment the man received at Kingston fell below the standard to which he was entitled to expect, and which impacted on the timely diagnosis of his lung cancer. He notes that the man had a persistent cough and breathlessness over a period of months. According to the National Institute for Health and Clinical Excellence (NICE) guidelines for the diagnosis and treatment of lung cancer (issued in April 2011), patients with a cough which lasts for more than three weeks or chest/shoulder pain should be referred for an urgent chest X-ray. In a report we issued earlier this year about an earlier death at Kingston there was also a failure to follow NICE guidelines about acute chest pains. We make the following recommendation, based on the clinical reviewer's:  
  
**The Head of Healthcare should ensure that all NICE guidelines, including those for the management of a persistent cough, are followed by all clinical staff.**

58. The reviewer concludes that many of the other omissions and failings detailed in this section occurred because of a lack of standard operating procedures in

healthcare at Kingston and a lack of team working, often because there was a reliance on locum doctors. Had this not been the case, and had not so many different staff been involved in the man's care, staff might have realised the man had not been referred for the chest X-ray as suggested by Dr C in March, that the orthopaedic referral had been rejected in April or that the two week rule referral had not been made in June. We make the following recommendations based on the clinical reviewer's:

**The Head of Healthcare should implement standard operating procedures which ensure that actions arising from clinical contacts in the prison and letters and reports received by the prison are dealt with in a timely fashion and documented in the records.**

**The Head of Healthcare should ensure that requests to and results of investigations from the local hospital are transferred electronically.**

**The Head of Healthcare should ensure appropriate staffing of medical and nursing posts at HMP Kingston to improve continuity of care by:**

- **employing a full complement of regular nursing and medical staff,**
- **ensuring that cases causing concern are effectively handed over between members of the healthcare team, and**
- **involving all members of the clinical team in clinical audits and governance, such as significant event reviews and reviews of performance.**

59. The clinical reviewer writes that, following any death in prison, a Serious Incident Requiring Investigation (SIRI) process should be followed. The purpose of a SIRI is to establish learning points and ensure lessons are learnt. At the time of writing the draft report, we had not been provided with a copy of the SIRI report, despite requests. In February 2013, we were given a copy of the report, which was finalised in January 2013. At the time of writing the draft report, he concluded that Kingston had not fully identified the evident failings in the care afforded to the man. In July 2012, in a report into another death at Kingston in December 2009 (our report was delayed because of police investigations), we made the following recommendation, which we repeat:

**The Head of Healthcare in conjunction with Solent Healthcare should ensure that a prompt local investigation is carried out following any serious incident involving healthcare (in keeping with normal NHS Serious Incident policy) and must ensure that the report is shared with the commissioner of healthcare in the establishment, so that any lessons can be learned at the earliest opportunity.**

60. Despite finding that the man did not receive equivalent care to the community, the clinical reviewer notes that, because of the extent of the cancer, even had it been diagnosed earlier, it is unlikely that the prognosis would have been very much better. However, an earlier diagnosis might have affected the man's treatment options, made him more comfortable and given him more time to re-establish contact with his family.

## **Informing the man about his condition and treatment**

61. The man was told that he had inoperable lung cancer on 27 June by hospital staff. There is nothing in his medical record to suggest that either Dr C or Dr D had discussed their earlier suspicions that the man might have had cancer with him.
62. On 27 June, the modern matron telephoned the hospital for an update. He noted that the man knew he had inoperable lung cancer but that he might be suitable for palliative chemotherapy and radiotherapy. (In some cases, patients with terminal cancer receive treatment to slow the progression of the disease and prolong life.) The modern matron recorded that the doctor had told the man that he might live for between six and 12 months if he had the treatment and for two months if he did not. The man was asked to think about what treatment he wanted to receive and hospital staff agreed to discuss this with him again the following week. He wrote that he would contact the ward at the beginning of the following week to discuss the man's decision.
63. However, over the following few days, the man's condition deteriorated rapidly. By 2 July, he was breathing oxygen through a mask and the hospital team discussed with him whether he wanted to be resuscitated if he stopped breathing. The man said that he wanted to be resuscitated. The hospital records suggest that the man did not always seem to fully understand that his condition was terminal and sometimes referred to there being a cure for it.
64. At 7.30am on 3 July, the man stopped breathing but was successfully resuscitated by hospital staff. At 8.20am, he stopped breathing once again, and despite the efforts of hospital staff, his death was pronounced at 8.30am.
65. In interview, the modern matron was asked whether he or any other member of healthcare staff had considered visiting the man in hospital to ensure that he understood his diagnosis and prognosis. He said that he received mixed messages from the hospital about the man's condition and, at some points, thought that his health was improving. He said that he planned to visit the man the week after he was admitted to hospital, but the man died before he could do so.
66. The man's personal officer and Senior Officer B, who spent time with the man as escort officers while he was in hospital, were asked whether they thought the man understood the seriousness of his condition and his treatment options. The man's personal officer said that he was reluctant to discuss the man's health with him. He said that sometimes the man seemed to understand his situation and at other times he appeared confused. Senior Officer B was not sure that the man had fully understood what he was told by hospital staff.
67. Clearly, there were aspects of the man's diagnosis and treatment that hospital staff were best placed to discuss with and explain to him. However, he had been asked to decide whether he wanted to accept palliative treatment, which, he was told, might extend his life expectancy. Hospital staff would not have been able to discuss with him how his status as a prisoner might affect his choices. The NHS

guidance on end of life care for prisoners, 'The route to success in end of life care – achieving quality in prisons and for prisoners' emphasises that it is the prison's role to have "open and honest discussions about prognosis and possible realistic future care options". We believe that it would have been appropriate for someone from the prison to have visited the man shortly after his diagnosis to discuss the implications with him.

**The Governor and Head of Healthcare should ensure that when a prisoner is given a terminal diagnosis and is an inpatient in hospital, the prisoner is visited promptly by a senior manager and member of the healthcare department to discuss and coordinate future care options.**

### **The man's medical appointments and treatment**

68. The man did not return to Kingston from Queen Alexandra Hospital and so his care was coordinated and provided by the hospital. The man's condition deteriorated very quickly once he had been admitted. As a result, he did not have any chemotherapy or radiotherapy. As his condition deteriorated, he was given oxygen to help him breathe more easily.
69. The clinical reviewer identifies no issues in the care provided to the man at Queen Alexandra Hospital once the diagnosis had been made.

### **The man's pain relief and medication**

70. The man had suffered with nerve pain in his arm for many years and was prescribed medication for this. Between February and April 2012, doctors and the modern matron altered his prescriptions several times to try to manage the pain better.
71. In April 2012, the man complained of intense pain on his left side and so his dose of gabapentin (which he had been prescribed for some years) was increased. The clinical reviewer agrees that this was an appropriate response and apparently helped to manage the pain.
72. Once in hospital, the man was treated with oxygen and morphine when his symptoms worsened. The clinical reviewer identifies no problems with the administration of pain relief or other medication to the man.

### **Liaison with the man's family**

73. The man had apparently had little recent contact with his family. On 27 June, after he was diagnosed with terminal cancer, Senior Officer B, who was with the man at hospital, asked him if he wanted his family to be contacted. The man said that he did not, but he asked that his solicitor be informed. The SO said he told the man that prison staff could not contact his solicitor, only his nominated next of kin. The SO told the man that he could telephone his solicitor himself if he wished.

74. The next day, 28 June, the man agreed that his family could be contacted. His son was listed as his next of kin and prison staff tried to contact him using the telephone number the man had given some months earlier, but it was incorrect. Senior Officer B said that the man had a list of telephone numbers in his diary which they tried but they too were incorrect. The Head of Security telephoned the man's solicitor that day but she did not have the correct contact information for the man's son either. After the man's death, his solicitor passed the telephone number she had (which was incorrect) to the Coroner for his office to take forward.
75. The man's personal officer said that he regularly asks the prisoners for whom he is personal officer to confirm the contact details of their next of kin. He said that the man had done so not long before he became ill. It appears that that the information the man gave was incorrect.
76. After the man's death, Officer B was appointed as the prison's family liaison officer. The investigator was told that during the man's illness, Kingston did not have a trained family liaison officer available. As a result, Senior Officer B, the head of security and other senior prison staff took responsibility for trying to trace the man's family. Once Officer B was appointed, he asked the local police to help. On 11 July, the police gave the prison telephone numbers for the man's son and his former wife. The officer left messages for them both. The man's ex-wife was the first to return the call and the officer broke the news of the man's death to her. She informed her son, who spoke to the officer on 12 July.
77. In line with national guidance, the prison offered to make a financial contribution towards the cost of the man's funeral. Most of the man's property was returned to his family shortly after his death. Some further items were found later and returned in October.
78. The man's son was concerned that it had taken the prison so long to inform him of his father's death. At the consultation stage, the man's son told us that he had visited his father in prison and they had, at one point, spoken regularly on the telephone. As a result, he believed that the prison should have had both his address and contact telephone number on file. It is regrettable that he could not be contacted sooner, but we are satisfied that the prison made all reasonable efforts to find him.

### **The man's location**

79. Until he went to hospital on 25 June, the man lived on a standard prison wing. As he was not discharged from hospital, his location after his terminal illness was diagnosed was not an issue and he remained in hospital till he died. However, the modern matron had provisional discussions with HMP Winchester about the man transferring there if he was discharged from hospital as he would need a prison with 24 hour healthcare cover.

### **Compassionate release**

80. Early release on compassionate grounds is a means by which prisoners who are dying can be permanently released before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out as follows in Prison Service Order (PSO) 4700:
- a. the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and
  - b. the risk of re-offending (particularly of a violent or sexual nature) is minimal; and
  - c. further imprisonment would reduce the prisoner's life expectancy; and
  - d. there are adequate arrangements for the prisoner's care and treatment outside prison; and
  - e. early release will bring some significant benefit to the prisoner or his/her family.
81. 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). Various reports are required to make up the application, including from the prison doctor (usually supported by further information from the hospital consultant or equivalent expert), the prisoner's offender manager and the Governor.
82. The modern matron discussed the man's prognosis with the Deputy Governor on 27 June. The Deputy Governor confirmed that, on the information given by the hospital, the man would be eligible for early release on compassionate grounds if he chose not to undergo palliative chemotherapy or radiotherapy. He suggested that they began the process of compiling reports while the man considered his options. The man was informed.
83. On 28 June, the Head of Security noted that the man's offender supervisor and offender manager did not currently support his early release. H explained that this was based on the information available at the time, which was that the man might have up to a year left to live. He said that decisions about whether to apply for compassionate release are kept under review. On 2 July, the modern matron asked the hospital for written confirmation of the man's diagnosis and prognosis. Unfortunately, the man's condition deteriorated quickly before any further progress on his possible compassionate release was made.
84. We are satisfied that Kingston took appropriate steps to consider whether the man was suitable for compassionate release.

### **Palliative care plans**

85. 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. There are various examples of end of life care pathways.
86. The man was diagnosed with terminal cancer on 25 June and, at that point, was told that he might be suitable for palliative treatment. In fact, his health deteriorated very quickly and he did not return to prison from hospital. Although there were plans for the man to transfer to Winchester should he return from hospital, as he had a terminal diagnosis, we would have expected Kingston to have begun an end of life care pathway for the man. There is no evidence of one in his medical record. The modern matron said that a palliative care protocol had been in place at Kingston for some time but had been formalised since the man's death. We make the following recommendation in relation to end of life care:

**The Head of Healthcare should ensure that a formal end of life care pathway is followed when prisoner is diagnosed with a terminal illness.**

#### **Restraints, security and bed watch**

87. 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.
88. 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.
89. On 25 June, a risk assessment was carried out before the man was taken to hospital for what appeared to be a routine appointment. The risk assessment recorded that the man's behaviour in prison had been good but that he posed a medium risk to the public and of escape. The man maintained his innocence of his offence and had not completed any offending behaviour work. There were no medical objections to the use of restraints and it was decided that the man should be handcuffed to an officer and be accompanied by two officers. The risk assessment was authorised by the head of security. Later that day, when the man was admitted as an inpatient, the risk assessment was reviewed. The level

of restraints was changed to an escort chain (a length of chain with a handcuff at each end for the prisoner and an officer).

90. On 28 June, the risk assessment was reviewed again. The man had now been diagnosed with terminal cancer. The review was carried out by the head of security, who noted the terminal diagnosis but wrote that the man was considered to pose a high risk to the public and was still fully mobile. The head of security concluded that restraints should remain in place until or unless the man's condition changed.
91. The risk assessment was reviewed again on 2 July and noted that the man's condition had deteriorated over the weekend and that he was being treated with oxygen. However, the man was still regarded as mobile and, therefore, to pose a risk. While the man was in hospital, nurses carried out daily assessments of, amongst other things, his mobility. On each occasion, including on 2 July, they concluded that the man was independently mobile and did not need assistance moving in bed or around his room. They did not assess whether he was fit enough to escape. The level of restraints remained the same.
92. The restraints were not removed until 7.30am on the day of the man's death, when the man stopped breathing and was undergoing emergency treatment. This was just one hour before he died.
93. The head of security explained that the decision to keep the man in restraints had been made as a result of the available information, including the nature of his offences, his previous convictions and the fact that, according to OASys (Offender Assessment System which is used in the criminal justice system to measure an offender's needs and risks) he was still considered to pose a high risk to the public. He knew that the man had been diagnosed with a terminal illness but that, with treatment, he was expected to live for up to a year. On that basis, he believed that the level of restraints applied was appropriate.
94. We have considered whether the use of restraints was justified and based on an appropriate assessment of risk. The review of the medical record and interviews with officers who spent time with the man in hospital indicate that, in the days before his death, his health had deteriorated significantly. He was being treated with 60 percent oxygen and he had periods of confusion. There was no security intelligence to suggest that the man had any intention of attempting to escape nor that he had any friends or family who might try to assist him. Moreover, it is hard to accept that, in his state of health, he would have been able to evade two officers. Although the head of security said he remained a high risk to the public, this did not accord with his security category or the risk assessment when he was taken to hospital which said he was a medium risk.
95. Both the head of security and the Governor of Kingston emphasised that the risk assessment process includes consideration of treating prisoners with humanity and decency. However, we are not persuaded that the risk assessments properly took into account the man's health and the impact this had on his risk, or that they justified restraining him almost until his death. We make the following recommendation:

**The Governor should ensure that risk assessments for prisoners admitted to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.**

## **CONCLUSION**

96. The man was diagnosed with lung cancer on 25 June. He died in hospital just over a week later. He had been complaining of a persistent cough, shortness of breath and pains in his upper left side for some time. He was seen regularly by healthcare staff but the cancer was not diagnosed. A doctor suspected he had lung cancer in February but his concerns were not followed up. The failure to diagnose the cancer earlier was in part because of incorrect information received from the hospital, however, there were a number of failings at Kingston and we have made a number of recommendations as a result. We conclude that the man did not receive the standard of clinical care he was entitled to expect.

## RECOMMENDATIONS

NOMS accepted all of the recommendations at the draft report stage.

1. The Head of Healthcare should ensure that all NICE guidelines, including those for the management of a persistent cough, are followed by all clinical staff.
2. The Head of Healthcare should implement standard operating procedures which ensure that actions arising from clinical contacts in the prison and letters and reports received by the prison are dealt with in a timely fashion and documented in the records.
3. The Head of Healthcare should ensure that requests to and results of investigations from the local hospital are transferred electronically.
4. The Head of Healthcare should ensure appropriate staffing of medical and nursing posts at HMP Kingston to improve continuity of care by:
  - employing a full complement of regular nursing and medical staff,
  - ensuring that cases causing concern are effectively handed over between members of the healthcare team, and
  - involving all members of the clinical team in clinical audits and governance, such as significant event reviews and reviews of performance.
5. The Head of Healthcare in conjunction with Solent Healthcare should ensure that a prompt local investigation is carried out following any serious incident involving healthcare (in keeping with normal NHS Serious Incident policy) and must ensure that the report is shared with the commissioner of healthcare in the establishment, so that any lessons can be learned at the earliest opportunity.
6. The Governor and Head of Healthcare should ensure that when a prisoner is given a terminal diagnosis and is an inpatient in hospital, the prisoner is visited promptly by a senior manager and member of the healthcare department to discuss and coordinate future care options.
7. The Head of Healthcare should ensure that a formal end of life care pathway is followed when prisoner is diagnosed with a terminal illness.
8. The Governor should ensure that risk assessments for prisoners admitted to hospital fully take into account the prisoner's health and circumstances and are based on the actual risk the prisoner presents at the time.