PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in October 2011 at hospital, while in the custody of HMP Hewell

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is a report into the death of a man. He died of lung cancer in October 2011 at hospital following his release on temporary licence from HMP Hewell. He was 51 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to conduct a clinical review into the standard of healthcare the man received while in custody at HMP Hewell. Hewell co-operated fully with the investigation. I apologise for the delay in issuing this report.

The man was referred in a timely and appropriate manner when he first presented with symptoms, was able to attend relevant appointments and received as much advice about his condition as was available. However, he suffered from a particularly aggressive form of lung cancer and lived for only a short time after diagnosis.

During the week the man spent in prison following his diagnosis, the healthcare team struggled to ensure he remained pain free. The investigation concludes that his pain could have been managed better through improved liaison with the pharmacy provider and the input of specialists from the local hospice. In addition, liaison with his family could have started at an earlier stage.

However, while the investigation found some areas where practice might have been improved, I conclude that the man received care equivalent to that he might have expected 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 **October 2012**

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SUMMARY

1. The man was about 18 months into a five year prison sentence when, on 23 September 2011, he told healthcare staff he was short of breath, had pain in the right side of his chest and was coughing up phlegm. He was prescribed a course of antibiotics, but his condition did not improve. On 5 October, doctors at the prison arranged blood tests, which proved to be abnormal and he was admitted to hospital.

2. While at hospital, the man was diagnosed with lung cancer. He was discharged back to Hewell on 8 October to await a biopsy, which would determine the stage of the cancer and, therefore, his likely prognosis and treatment options. The clinical reviewer concludes that he was referred to hospital appropriately by prison healthcare staff.

3. Although he was usually a resident of the lower security 'open' side of Hewell, the man was allocated a bed in the inpatient unit on the higher security 'closed' side of the prison on his return. (The open side does not have an inpatient unit.) This was so he could be monitored while his pain control medication was instigated. There was some difficulty obtaining the correct medication for him and the clinical reviewer recommends that the Head of Healthcare liaise with the pharmacy provider to ensure that palliative medication is always available without delay. We also recommend that specialists from the local hospice are contacted for advice on pain relief.

4. In line with his wishes, the man returned to the open side of the prison on 13 October. He visited hospital on 14 October for his biopsy, returning to the prison the same day. On 15 October, he was admitted to hospital, and he did not return to the prison before he died several days later.

5. The man's family were contacted by the prison's family liaison officer after his death. We recommend that family contact is made at an earlier stage when a prisoner is diagnosed with a terminal illness.

6. The man was diagnosed with an aggressive cancer and spent just a week in prison following his diagnosis. Although we have highlighted some areas of practice that might be improved, we agree with the clinical reviewer's conclusion that the care he received was equivalent to that he might have expected in the community.

THE INVESTIGATION PROCESS

7. An investigator carried out the investigation and first visited Hewell on 2 November 2011. He reviewed the man's prison records and was shown around both the open and closed parts of Hewell, including the dormitory accommodation where he was resident before he went to hospital.

8. Notices about the investigation were issued to staff and prisoners at Hewell asking anyone who had relevant information to contact the investigator. No one came forward.

9. The local PCT appointed a clinical reviewer to conduct a review of the clinical care the man received in custody. The final clinical review was received on 7 June 2012. We apologise for the late issue of this draft report, in part because of the delayed clinical review, and also because of staffing issues was one of a number of delayed cases which we are striving to clear.

10. HM Coroner for Worcestershire was informed of the investigation. A copy of the investigation report will be sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's daughter and sisters to explain the purpose of this investigation and to invite them to raise any issues for consideration. They did not raise any concerns at the time.

12. Comments on the draft report were received from the National Offender Management Service. All the recommendations were accepted and further information has been included.

HMP HEWELL

13. HMP Hewell was created when three prisons on the same site were merged in June 2008. There are now only two parts to the prison – an open side (houseblock 8) and a closed side (houseblocks 1 - 6). The closed side houses prisoners who are category B prisoners, including those on remand. The open side accommodates prisoners who are lower risk, category D prisoners.

14. There are four categories of prisoner: A, B, C and D, with category A prisoners being the most dangerous. The man was a category D prisoner, and therefore predominantly resident in houseblock 8. (Category D prisoners are considered low risk and unlikely to escape.) Prisoners on houseblock 8, such as he, if assessed as suitable, are able to visit their family at weekends around once a month, via a process commonly known as home leave.

15. Health services at Hewell are provided by the local PCT. The main healthcare unit, on the closed side of the prison, provides inpatient facilities and 24 hour nursing care. Clinics are also held on a daily basis in a smaller facility on the open side.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons conducted an announced inspection in November 2009. The Inspectorate reported that "both staff and prisoners expressed considerable dissatisfaction with life in houseblock 8", but healthcare provision on that houseblock was particularly good. The Inspectorate noted that there was a nurse who managed both palliative and end of life care, with external palliative specialists providing advice and guidance.

Independent Monitoring Board

17. The Independent Monitoring Board (IMB, a body of unpaid volunteers from the local community whose role is to monitor the prison to see that proper standards of care and decency are maintained) report for 2010 -11 reported that there had been some administrative difficulties in the reporting year due to a change of healthcare provider.

Previous deaths at Hewell

18. The man's death was the first of four deaths from natural causes at Hewell in 2011. None of the other investigations raised any issues pertinent to the circumstances surrounding his death.

ISSUES

19. The man was convicted on 12 March 2010 of causing grievous bodily harm and imprisoned at HMP Hewell to await sentencing. It was his first time in prison. He received a five year sentence on 14 June 2010 and returned to Hewell, where he spent all of his time in custody.

20. When he arrived in custody he had a number of health problems, the most pressing of which was pain in his right arm. He was also a heavy smoker and had been suffering with depression for some time. He was diagnosed with high blood pressure and high cholesterol, for which he was prescribed medication. He also reported various pains in his neck, arms, back and legs. These conditions were adequately treated by healthcare staff.

The diagnosis of the man's terminal illness

21. On 8 September 2011, the man visited the healthcare clinic and told a nurse that he was not feeling well. He was suffering from hot flushes was short of breath and appeared pale and clammy. The nurse arranged for him to see the visiting GP, who reviewed his medication but did not make any other diagnosis.

22. The man saw the GP again on 23 September, when he reported chest pain and pain in the right side of his neck. The GP prescribed antibiotics for a chest infection. The clinical reviewer describes this as an appropriate consultation with suitable treatment. On 3 October, he saw a nurse because he was very short of breath and seemed quite panicked by this. She calmed him down and made arrangements for him to see the GP on 5 October.

23. He subsequently saw the GP on 5 October, who took a blood sample for testing, (including a D-dimer test used to determine if someone's blood is prone to clotting). The results of the blood tests were abnormal, so he was admitted to hospital for further tests. Doctors at the hospital were concerned that he might have a pulmonary embolism (a blockage of the main artery of the lung caused by a blood clot, which can be fatal). They organised for a CT scan to be undertaken, which was done on 6 October. (A CT scan is a computerised tomography scan, a specialised x-ray which gives very clear pictures of the inside of a person's body.) The scan showed that the likely cause of his illness was a large cancerous growth in or on his lungs, but that he would need further tests to determine the exact nature of the growth.

24. In his clinical review describes the man's cancer as "extremely aggressive". By the time of diagnosis, it had spread beyond the lungs, despite there being no presenting symptoms. The clinical reviewer finds no evidence that his earlier contact with health services would have led clinicians to suspect that he was suffering with a cancerous growth. He comments that the GP took unusual investigatory steps by asking for a D-dimer test to be done. But for this, he may not have been admitted to hospital on 5 October and diagnosed when he was.

25. This investigation finds that Hewell's medical services referred the man to local hospital services in a timely and appropriate manner.

Informing the man about his condition and treatment

26. On 7 October, doctors at the hospital informed the man of his condition so far as they knew at that time. They explained that he would return to prison on 8 October until a biopsy test was arranged at another hospital. The biopsy would confirm in more detail what type of cancer he had, and what treatment options would be suitable.

27. He was seen by the palliative care nurse at the hospital. (Palliative care is a form of healthcare that focuses on relieving and preventing the suffering of terminally ill patients.) It was NHS staff who broke the news of his terminal illness and he was not accompanied by staff from the prison. He returned to Hewell to await the biopsy, having been prescribed various medications to treat his symptoms.

28. His medical record indicates he expressed frustration at the lack of information from the hospital regarding his investigations. The clinical reviewer considers that any delays were due to necessary multi-disciplinary team discussion that must take place at hospital to determine a treatment plan. He writes:

> "There is recorded evidence that Healthcare regularly reviewed the man during these days, kept him informed of events, involved him in his own care and attempted to receive information regarding his further care from the appropriate hospitals."

29. The attempts to gain information about the man's prognosis and treatment were frustrated by NHS services not having the answers themselves. It would have been unreasonable for prison health services to speculate about what courses of action might have been taken, and it was therefore understandable that they were not in a position to keep him better informed. Unfortunately his condition deteriorated before sufficient tests were completed to answer the questions he had.

30. He received information about his condition as quickly as it became available and in that respect he was treated equitably with people in the community.

The man's medical appointments and treatment

31. The man was discharged from hospital on 8 October and moved into the inpatient unit in the closed part of the prison on his return to Hewell. He was monitored by healthcare staff and was assessed by a GP every morning. Once it was agreed that his pain was adequately managed, he was moved back to houseblock 8 on the open side of Hewell on 13 October. He attended hospital for a day on 14 October for his biopsy and returned to the prison that evening.

32. The next day, he reported that he had vomited and a visiting GP examined him. She thought he needed admitting to hospital in order that his ascites (swelling of his abdomen due to fluids collecting) could be drained. (There is no mention in the records of him having ascites before the examination by the doctor.) He was subsequently admitted to hospital.

33. The man deteriorated quickly in hospital and, by 17 October, was unable to eat and drink properly. He transferred to another hospital on 18 October, where it was planned he would undergo surgery later that month. Several days later he died as a result of his lung cancer. It is unclear from the medical records whether a definitive result from his biopsy was ever received by prison doctors, but he was admitted to hospital the day after the biopsy was taken.

34. The man was a category D prisoner and there were therefore no constraints on his attending appointments or receiving treatment. The investigation finds that he received treatment and attended appointments at the local hospital according to his needs.

The man's pain relief and medication

35. After his diagnosis on 7 October, the man was discharged back to prison on 8 October. He was originally admitted to the healthcare inpatient unit at Hewell in order to ensure his medication was working and to manage his symptoms. However, in the next couple of days there was some difficulty ensuring he remained pain free.

36. On 8 October, the man left hospital with a prescription for various medications, including morphine, a strong painkiller. The doctors at Hewell prescribed the drugs recommended by the hospital. On the morning of 10 October, following a review by a visiting GP to the prison, he was prescribed stronger painkillers (slow release tablets that are designed to keep people pain free for longer periods of time). In the early evening, the GP added some additional painkillers to supplement the long acting morphine he had prescribed that morning. Later that evening, another GP prescribed even more morphine, to be given more frequently for breakthrough pain, as he was still experiencing severe pain. She also prescribed an anti-inflammatory (diclofenac) to supplement the morphine and paracetamol.

37. On 11 October, a GP saw him again, who told her that his pain was much improved as a result of the diclofenac tablets. He wanted to return to houseblock 8 and said he would rather go back there and have his pain relief medication adjusted whilst he lived on the open side of the prison rather than remain in the closed side. An entry on the same day confirms not all of his morphine medication was available from the local pharmacy. The remaining medication arrived on 12 October having been prescribed late on 10 October.

38. The man slept well on the night of 11 October and was given pain relief early on 12 October. There are no further records of him being in pain on 12 October and an entry to say that he scored himself as 1 out of 10 on the pain

scale on 13 October. (A pain scale is used as a way of judging how much pain a patient has with 1 being a very low score and 10 being very high.) He returned to houseblock 8 on the morning of 13 October.

39. He was prescribed a number of different forms of painkiller, including morphine. The clinical reviewer notes concern by staff that some of the morphine-based drugs were not available at the prison. He says this "caused frustration amongst medical staff who were trying to titrate [adjust] his medication and to manage his pain". He also says that this potentially had an impact on ideal symptom control, and was sometimes not sufficient to completely eliminate the man's pain. We agree with his recommendation that:

The Head of Healthcare should work with the pharmacy provider to ensure appropriate medication is available when requested for palliative care purposes without delay in order to allow early symptom control.

40. The difficulties in managing the man's pain control might have been aided by the involvement of specialists from a local hospice. It is not unusual for a palliative care consultant or Macmillan nurse to visit patients in prison to give advice on pain relief or other ways of making the patient comfortable.

The Head of Healthcare should ensure patients diagnosed with terminal cancer receive specialist support from relevant outside agencies.

Liaison with the man's family

41. The man went on home leave on 9 October 2011, during which time he told his family the news of his recent diagnosis. There is no evidence that prison staff contacted his family before his death.

42. Prison Service Instruction (PSI) 64/2011 sets out the current instructions for family contact when a prisoner has been diagnosed with a terminal illness:

> *"Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill."*

43. Such an arrangement ensures that the family have a point of contact should they have any concerns about their relative. It benefits the prison to have established a relationship should they need to contact the family in the event of a sudden deterioration.

The Governor should ensure that family contact is established as soon as possible once a prisoner is diagnosed with a terminal illness.

44. The man had told the prison that his daughter was his next of kin. When he died, hospital staff broke the news to his daughter. There is no record of whether his family were present at the time of his death, although they had visited him in hospital.

45. Once the prison had been informed of the man's death, their family liaison officer, a prison chaplain, contacted his sister. She was initially contacted as she had been his main support during his terminal illness and because his daughter was aged 16 at the time. His sister confirmed that her niece should be considered his next of kin and arrangements were made to contact her.

46. The man was due to perform at a concert event at the prison and following his death, members of his family were invited to attend the concert. The family were also assisted by the prison with funeral expenses and arrangements in line with national guidance.

The man's location

47. The man was a category D prisoner at the time of his diagnosis on 7 October. When he returned from hospital on 8 October, he initially lived in the inpatient unit of the closed side of the prison where there are nurses present 24 hours a day. He initially had concerns that being in the closed prison would mean he was unable to go on his home leave arranged for the following day. He was reassured that this would not be the case and was able to visit his family as planned.

48. The man lived on the closed inpatient unit until 13 October, but expressed concern and frustration at being in the unit over those few days because he wanted to return to his houseblock. He required 24 hour nursing care and monitoring so that prison healthcare staff could assess his needs. There is no inpatient facility in the open side and nursing staff are only present for short periods of time on that side of the prison (mornings Monday to Friday).

49. The clinical reviewer comments that the man remained on the inpatient unit to allow his medication to be adjusted to manage his pain. His pain had reduced by the time of his return to the open side of the prison (although we have earlier highlighted concerns about his pain management at Hewell). He also required a ground floor room, so remained on the inpatient unit until suitable accommodation was available on houseblock 8.

50. On his return to houseblock 8, the man was located in a room that was annexed to the main residential unit in a more private area. During the few days that he was living on houseblock 8, nurses visited regularly to monitor him and ensure he received his painkillers throughout the day.

51. The prison accommodated the man in the open side of the prison because he wanted to live with his friends, his family would find it easier to visit and he would be treated as a category D prisoner in all things. When he got so unwell that he could not manage, he was transferred to hospital. We agree that it was appropriate for him to live on houseblock 8 at this time, in line with his wishes. We are satisfied that he was transferred to hospital as soon has his condition could no longer be managed in the prison.

Palliative care plans

52. Before he left hospital on 8 October, the man spoke to a palliative care nurse, who explained the ramifications of his recent diagnosis. He was then under the care of prison healthcare services from 8 October to 15 October (other than when he was on home leave on 9 October). A nursing care plan was written, which included provision for giving him food supplements to counter his loss of appetite, and a specialist pressure relieving mattress was ordered.

53. During his week at Hewell from 8 October, the results of his biopsy (taken on 14 October) were unknown. Given that neither his treatment options nor prognosis were known during the short period of time he was in prison following diagnosis, it is understandable that a formal end of life pathway was not followed. (An end of life pathway is a document that sets out how a patient will be cared for towards the end of their life. Among the benefits are that it helps carers plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives.) However some of the key principles of an end of life pathway were applied, such as respecting his wish to return to the open side of the prison.

Compassionate release

54. All prisoners who have not reached their automatic release date, conditional release date or parole eligibility date may apply for early release on compassionate grounds for medical reasons. In order to be released on compassionate grounds, a prisoner must have a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

55. The man was diagnosed with lung cancer on 6 October. Although the extent of the illness was not known, a nurse recorded that his prognosis was likely to be poor. He had a biopsy on 14 October, the results of which would determine the stage the cancer had reached, how likely it was to respond to treatment and his likely prognosis, but the results were not known before he died. After his readmission to hospital, a nurse telephoned the hospital on 19 October for an update, and was told that he was likely to remain in hospital for some time, but they were unable to give her a prognosis. There was no further contact with the hospital before his death several days later.

56. There is no evidence that an application for compassionate release on medical grounds was considered by the prison in the man's case. As a category D prisoner who had been granted home leave, his risk was low, but there was no clear prognosis. Given his terminal illness and critical condition, the prison could have started an application for compassionate release after he had been diagnosed. However, we do not feel that it was unreasonable for the prison to wait for the outcome of the biopsy or a prognosis, neither of which were known before he died.

57. We note that the man was released on temporary licence for the duration of his stay in hospital. (Release on temporary licence [ROTL] is a form of

release usually used to enable prisoners to participate in activities outside the establishment that directly contribute to their resettlement into the community. For example, he was released on temporary licence to stay with his family on home leave.) This meant that he could be treated in hospital without a prison officer accompanying him, and was appropriate in the circumstances.

Restraints, security and bed watch

58. As he was a category D prisoner, the man was released on temporary licence for each of his hospital visits, including both inpatient stays and outpatient appointments. This meant he was unaccompanied, and no restraints were used.

CONCLUSION

59. The man was diagnosed less than three weeks before he died. His deterioration was so quick that the extent of his illness had not even been formally established. During the seven days that he was back in the prison, the healthcare team struggled to ensure that he remained pain free. In part this was due to the nature of his condition (his cancer was extremely aggressive), but it was not helped by a failure to provide prescribed medication efficiently.

RECOMMENDATIONS

1. The Head of Healthcare should work with the pharmacy provider to ensure appropriate medication is available when requested for palliative care purposes without delay in order to allow early symptom control.

   Accepted: *Immediate contact will be made with the pharmacy provider in order to make arrangements for palliative care medication to be provided as soon as possible. In cases where it is indicated, staff will make arrangements to collect medication directly from the pharmacy provider.*

2. The Head of Healthcare should ensure patients diagnosed with terminal cancer receive specialist support from relevant outside agencies.

   Accepted: *The Healthcare team will liaise with a palliative care consultant or the Macmillan nursing team in appropriate cases.*

3. The Governor should ensure that family contact is established as soon as possible once a prisoner is diagnosed with a terminal illness.

   Accepted: *The local Safer Custody policy has been reviewed to include guidance regarding contact required with a prisoner's family when they have been diagnosed with a terminal illness or their physical condition has deteriorated rapidly. Additional staff have also been identified to carry out Family Liaison Officer duties at the prison.*