PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2014 at HMP Belmarsh

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 who died of cancer of the pancreas in July 2014 at HMP Belmarsh. He was 49 years old. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Belmarsh. The prison fully cooperated with the investigation.

The man was remanded to HMP Belmarsh on 21 April 2014, charged with serious offences. Doctors had diagnosed him with cancer in early 2013 and he had received intensive treatment in the community.

The prison received information about the man's condition and prognosis from his oncologist promptly, which clearly showed a terminal diagnosis. However, a clinician did not review the information and the man did not learn that his condition was terminal until he saw the letter during a GP review. This caused him significant additional distress. His condition deteriorated quickly and healthcare staff met his needs in prison effectively, helped by the advice of a community palliative care team. The man's nominated next of kin, a close friend, was able to visit him regularly and was at his bedside when he died during an evening in July.

While, overall, the clinical reviewer found that the man's clinical care was equivalent to that he might have expected to receive in the community, I am concerned that there was a delay informing him of his prognosis and ensuring he was given support. There were also some occasions when it took too long to get him effective pain relief medication. Nevertheless, the palliative care that he received at Belmarsh was of a good standard.

Although I understand that the man was regarded as a high security risk, I am concerned that the use of restraints when he went to hospital was not fully justified and did not take into account his very serious state of health at the time, a matter I have raised in previous investigations at Belmarsh.

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 **February 2015**

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SUMMARY

1. The man was remanded to HMP Belmarsh on 21 April 2014, charged with serious offences. Doctors had diagnosed him with cancer in early 2013 and he had received intensive treatment in the community before arriving at Belmarsh.

2. A prison GP obtained the man's community medical records and contacted his oncologist. On 25 April, the oncologist sent information including the results of a CT scan which had taken place the week before the man went to prison. The oncologist said that his condition was not treatable and that he had around three months to live.

3. Healthcare staff implemented appropriate care plans for the man's treatment and dietary needs. However, no one informed him of his prognosis and that he would not receive further active treatment until he noticed the consultant's letter during a consultation with a GP three weeks later. There is no evidence that staff offered him support at that time to help him come to terms with the diagnosis.

4. On 11 May, the man said that he was experiencing pain in his right side. A nurse asked doctors to prescribe oramorph (strong pain relief), but it was a further three days before he received the medication.

5. Healthcare staff involved the man in regular multidisciplinary team meetings and kept him informed of any changes to his medication as his condition deteriorated. He had appropriate facilities such as an air filled mattress and a comfortable chair. The staff kept in contact with the community palliative care team and regularly reviewed his medications. The palliative care team gave prison healthcare staff a step by step care and pain management plan, although there were still some occasions when it took a day to get him effective pain relief.

6. On 15 June, the man went to hospital for treatment for an infection and received intravenous antibiotics. Four officers escorted him to hospital and used an escort chain to restrain him. The hospital discharged him back to the prison healthcare unit on 20 June. By this time, he was frail and not able to mobilise safely on his own.

7. The man's condition deteriorated significantly over the next three weeks. He died on a day in July. His friend was with him at the time.

8. We are satisfied that overall, the man received an appropriate standard of care at Belmarsh, but we are concerned that there was some confusion and delay about informing him of his prognosis, a lack of initial support and occasional delays with pain relief medication. We do not consider that his condition was appropriately taken into account when he was restrained in hospital. We make four recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed two members of staff at Belmarsh on 27 August, and interviewed four members of staff and a prison GP by telephone in August and September. She informed the Governor of the preliminary findings of the investigation.

11. NHS London commissioned a clinical reviewer to review the man's clinical care at the prison.

12. We informed HM Coroner for Inner South London District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin, a close friend, and also his wife to explain the investigation. He informed them separately about the investigation process. They had a number of questions including whether the level of escort and restraints were appropriate, and whether the man's pain relief was sufficient.

14. The man's friend and wife received a copy of the draft report and indicated that they were satisfied with the findings.

15. The report was issued for consultation with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

16. The investigation has assessed the main issues involved in the man's care, including his treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his next of kin and family, and whether compassionate release was considered.

HMP BELMARSH

17. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds over 900 men. Care UK provides healthcare services at the prison. The healthcare department provides 24-hour care and has facilities on all the houseblocks, as well as in reception, and the first night centre.

Her Majesty's Inspectorate of Prisons

18. The most recent inspection of Belmarsh was in September 2013. Inspectors noted that Care UK, the new healthcare provider from early 2013 had made some improvements to what had previously been poor health services. Inspectors found there was an adequate range of nurse-led and specialist clinics, but prisoners were dissatisfied with the quality of health services. There were still many staff vacancies, covered by agency nurses, which inhibited the continuity of care and expansion of services. Inspectors noted that there were established arrangements for palliative and end-of-life care for terminally ill prisoners, but the prison did not have a palliative care policy to help ensure prisoners at the end of their lives received appropriate care.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to June 2013, the IMB noted that Care UK had a robust approach to dealing with inefficient staff and a strict policy on appraisals, performance management, staff development and training. The Board hoped to see this result in improvements in the delivery of healthcare to prisoners.

Previous deaths

20. This man's was the third death from natural causes in the last two years at Belmarsh. We have made previous recommendations before about communicating to prisoners serious information about their health and taking a prisoner's medical condition fully into account in the risk assessment process.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

21. The man was remanded into HMP Belmarsh on 21 April 2014 for serious firearms and assault offences. It was his first time in prison.

22. Doctors had diagnosed the man with pancreatic, liver and lymphatic cancer about a year before he arrived at Belmarsh and had treated him with chemotherapy and radiotherapy. In the week before his arrest, he had spent four days in hospital with an infection. In hospital, he had a CT scan to see if any further treatment was possible. He had not received the results of the CT scan before he arrived at Belmarsh.

23. An initial health screen noted he had cancer, was diabetic and had a blood clot in his right leg. A prison GP prescribed his medications, including insulin and pain relief. At a secondary health screen on 22 April, the man told a nurse that he was under the care of West Suffolk Hospital for cancer.

24. A prison GP requested the man's community GP records, and the clinic faxed these to the prison the same day. The record said that his cancer was advanced and inoperable and clarified his medications and treatments.

25. On 23 April, West Suffolk Hospital said the man had weekly appointments with his oncologist and had missed one that day. A prison GP contacted the hospital on 24 April for more information and referred him to the community palliative care team.

26. A faxed letter from the oncologist on 25 April explained that the man had undergone three rounds of chemotherapy from February 2013 to March 2014. The treatment had not been effective and the cancer had spread. A recent CT scan had shown the tumour in his liver had doubled and that more tumours had grown. No curative treatment was possible and his prognosis was less than three months. The letter did not explain whether the oncologist had told the man this information and there is no evidence that the GP or any other clinician saw the letter at the time, or shared its contents with the man.

27. On 29 April, the man asked a nurse when he would receive chemotherapy or see his oncologist. A prison GP saw him the next day and told him that the prison and hospital were rearranging his appointments, and a multidisciplinary meeting would discuss his condition and future care. He did not refer to the oncologist's letter.

28. On 9 May, the man asked a nurse about the outcome of the CT scan, which he had had the week before he arrived at Belmarsh and whether he was suitable for additional chemotherapy. She referred him to a GP. A GP saw him on 14 May. During the consultation, the man noticed the letter from his consultant and asked to read it. He was surprised and distressed to find that he was not eligible for any further treatment. He asked to be taken to hospital when his condition deteriorated, as he did not want to die in prison. There is

no evidence that the doctor or any healthcare staff discussed the letter or its implications any further with him at that time, or that staff offered him any support.

29. We are concerned that no one informed the man of the content of the oncologist's letter until over three weeks after it had been received. The man knew he had cancer before he arrived in prison and it appears that prison healthcare staff assumed that he was fully aware of his terminal diagnosis and life expectancy. The clinical reviewer said that this was a very unfortunate lapse in communication between healthcare staff and the man. Clinicians missed a number of opportunities to discuss the contents of the letter of 25 April with him. The records clearly show that administrators scanned the faxed letter from the oncologist into the man's medical record without a clinician considering or verifying it at the time. We make the following recommendations:

The Head of Healthcare should ensure that a clinician reviews incoming correspondence about the care and treatment of a prisoner, and acts on the information as necessary.

The Head of Healthcare should ensure that healthcare staff offer appropriate advice and support to prisoners who receive a terminal diagnosis.

The man's clinical treatment

30. When the man arrived at Belmarsh, healthcare staff implemented a care plan. This included discussions about medications, regular reviews with prison doctors about his physical health, an end of life pain management care plan (even though at the time he was not aware of his terminal diagnosis) which included referral to a doctor or Macmillan nurse when necessary. Staff also created a diabetes care plan to observe any adverse side effects to his medications, to monitor his bloods and urine and to assess the impact of the diabetes on his daily living.

31. On 11 May, the man asked a nurse for oramorph (pain relief). The nurse sent a task on the computerised medical record system for prison doctors to prescribe oramorph. Although the man saw two prison GP's on 12 and 13 May, he did not receive oramorph until 14 May.

32. The man attended a first multidisciplinary case conference on 21 May and asked to see a Macmillan counsellor. As the community palliative care team did not have Macmillan counsellors, staff placed him on the waiting list for a general counsellor. (He did not see a psychological support worker until 9 July.) The record of the meeting noted that healthcare staff were confident that the care at Belmarsh would reflect community care in terms of symptom control, with the advice of the community palliative care team when necessary. The staff agreed that the man's cell door hatch should stay open and he had a fan to help maintain a reasonable temperature. The man said

he was still waiting for the results of his scan (although by this time he had seen the consultant's letter).

33. On 23 May, a senior nurse, the Head of Safer Custody and a senior officer fully explained the letter from the clinical reviewer, which said he had approximately three months to live. He declined the offer of support from the Samaritans and said he would contact his solicitor to apply for bail.

34. On 11 June, the man began to complain of severe pain and oramorph was no longer effective. On 12 June, a prison GP reviewed him and prescribed one dose of a stronger, slow release, pain relief.

35. On 13 June, a prison GP noted that the man was deteriorating rapidly and complaining of severe pain in his back. A community palliative care consultant advised on a step-by-step care plan and pain management plan, which included a slow release pain relief. Although he complained of severe pain, this was not prescribed until 14 June. Anticipatory medication for end of life care was prescribed (for symptom relief such as anti-sickness, sedative medication and mouth care).

36. On 15 June, a prison GP treated the man with antibiotics for an infection. By the evening, he was very uncomfortable and his temperature had risen further. The GP sent him to hospital, where he received intravenous antibiotics for an abdominal infection and septicaemia (blood poisoning). He returned to prison on 20 June.

37. The man found it increasingly difficult to get in and out of bed. He was very swollen from his legs to his abdomen and said he had breakthrough pain (this is pain despite receiving pain relief). A prison GP reviewed the man and noted that his temperature had spiked in the last 24 hours. He prescribed oral antibiotics, in case the infection had flared up. Nurses took the man's basic observations every four hours and increased his pain relief. He had improved by the next morning.

38. On 26 June, a community palliative care nurse, a prison GP and two nurses discussed the man's condition and treatment. He had deteriorated significantly in the previous weeks; he had recurring high temperatures, swollen legs and ankles, and was immobile. Doctors prescribed injectable pain relief for when he was not able to swallow tablets.

39. On 2 July, a prison GP examined the man and advised that he should go to hospital to resolve the swelling. He said that he did not want to go to hospital, as it was not a comfortable, pain free journey. (He had found his previous hospital admission by ambulance painful.) The GP prescribed an additional diuretic to help reduce fluid retention.

40. On 3 July, the man said that he did not want to be resuscitated in a medical emergency and completed an order with a doctor the next day. Later on 4 July, nurses noticed he was confused and the oxygen saturations in his blood were low. They gave him an air filled mattress and special pillows to prevent

pressure sores, which he said made him more comfortable. The diuretic was not helping but he still refused to go to hospital. The doctor advised nurses to continue monitoring the man.

41. On a day in July, the man's friend, who he had nominated as his next of kin, visited him. At 4.55pm, she told healthcare staff that he was having difficulty breathing. A senior nurse went to his cell and noted that he had stopped breathing. He checked for signs of life, but found none. At 5.10pm, a prison GP confirmed that the man had died.

42. The nursing care the man received, particularly at the end of his life, was of a good standard. The palliative care team reviewed his pain relief regularly, and anticipatory medication was prescribed. However, there were occasional delays in him receiving his pain relief. Overall, the clinical reviewer was satisfied that the man's clinical care was equivalent to that he might have expected to receive in the community, but identified a training need in relation to pain relief for terminally ill prisoners. We make the following recommendation:

The Head of Healthcare should ensure that terminally ill prisoners receive effective pain relief and that healthcare staff involved in their care have appropriate training to deliver it.

The man's location

43. The man lived in the healthcare centre at Belmarsh so staff could closely monitor and care for him. As his condition changed, his needs were assessed and additional equipment ordered. Healthcare staff chased orders appropriately when there were delays.

44. The man told the multidisciplinary meeting on 21 May, that he would like to go to a hospice eventually. Healthcare staff kept in contact with the community palliative care team about his condition and the possibility of him moving to a hospice if the prison was not able to meet his needs.

45. On 17 June, when the man was in hospital, healthcare staff made a referral to the hospice but he did not meet the criteria of being in the last two weeks of his life. They referred him to the hospice again on 4 July. However, the community palliative care nurse said that she spoke to the man and his nominated next of kin about moving to a hospice and at that stage, he said he did not want to be moved from Belmarsh as his visitor was able to come in regularly and his needs were being met.

46. We are satisfied that the man's location was appropriate and was suitable for his needs. The community palliative care team advised about his care and the best environment for him. Healthcare staff appropriately considered hospice care.

Restraints, security and escorts

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity. 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.

48. A judgment 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 the risks posed by the same prisoner when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. It found that handcuffing a prisoner receiving chemotherapy (and by implication other life saving treatment) was degrading and also likely to be regarded as inhumane unless justified by other relevant considerations.

49. The man was a category A prisoner (considered a high risk to the public). He went to hospital for treatment of an infection on 15 June. At the time, he was very unwell and reliant on a wheelchair. A risk assessment for the escort considered him to be a medium risk to the public, of escape and of assistance to escape. He was a low risk to medical and prison staff, and of hostage taking. There were no noted behavioural issues. A prison GP and the man's probation officer advised that restraints should not be used because of the severity of his condition.

50. The Head of Security agreed the risk assessment which said the man should be escorted by a senior officer and three officers, in line with the Local Security Strategy for category A prisoners. He discussed the escort with the acting Deputy Director of Custody (now Governor of Belmarsh). They decided that, as the man was a category A prisoner and it was unknown if he was affiliated with any serious criminal organisations, he would be restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.)

51. On 17, 18 and 20 June, the man complained his wrists were swelling and the handcuff was painful. He asked for the escort chain to be removed. The risk assessment was reviewed daily and although it was noted that his condition reduced his risk of escape, the escort chain remained in place.

52. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. As the man was unable to mobilise without a wheelchair and very unwell with an infection, it is difficult to understand how he would have been a risk of escape, especially as four officers accompanied him. A prison GP said that security staff often overrode medical decisions regarding restraints and this was not an isolated incident. The restraints caused the man pain because of his swelling, and it was clearly noted that his medical condition impacted his level of risk of escape, yet the

daily management review did not take this into account. All decisions about restraints appear to have focused on his alleged offence rather than his condition at the time.

53. We have raised the issue of the need to ensure appropriate risk assessment with Belmarsh before. We are concerned that a very sick prisoner, such as this man, was restrained without any clear evidence of risk of escape. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

Liaison with the man's next of kin and family

54. On 12 May, the prison appointed two family liaison officers.

55. The security department cleared the man's nominated next of kin, his friend, and also his wife for visits to him in the healthcare centre. The man's friend visited frequently, and daily as his condition deteriorated. The prison made provision for her to stay the night if this was needed.

56. Healthcare staff, the prison chaplaincy and the two family liaison officers supported the man's friend and his wife and kept them informed of his condition and any changes. His friend was with him when he died.

57. The man's funeral was on 30 July. The prison made a financial contribution, in line with national guidance.

Compassionate release

58. The man was a remand prisoner and not eligible for release on compassionate grounds. His legal representatives unsuccessfully attempted to have him released on bail. This was a matter for the courts and outside the remit of this investigation.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a clinician reviews incoming correspondence about the care and treatment of a prisoner, and acts on the information as necessary.

2. The Head of Healthcare should ensure that healthcare staff offer appropriate advice and support to prisoners who receive a terminal diagnosis.

3. The Head of Healthcare should ensure that terminally ill prisoners receive effective pain relief and that healthcare staff involved in their care have appropriate training to deliver it.

4. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

ACTION PLAN: (the man) – HMP Belmarsh

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that a clinician reviews incoming correspondence about the care and treatment of a prisoner, and acts on the information as necessary.	Accepted	All information received from GP's is scanned onto system 1 by the administration team. GP's have been reminded to read and action all necessary information.	Completed Head of Healthcare
2	The Head of Healthcare should ensure that healthcare staff offer appropriate advice and support to prisoners who receive a terminal diagnosis.	Accepted	Prison healthcare in conjunction with the Bexley palliative care team and HMP Belmarsh have developed an end of life care strategy. Prison healthcare is in the process of implementing this strategy. Staff are involved in training to offer appropriate advice and support to prisoners who receive a terminal diagnosis. All staff on the inpatient unit will attend the introduction to end of life training by May 2015. Five staff are trained at present.	May 2015 Head of Healthcare
3	The Head of Healthcare should ensure that terminally ill prisoners receive effective pain relief and that healthcare staff involved in their care have appropriate training to deliver it.	Accepted	As above, HMP Belmarsh is currently in the process of implementing the end of life care strategy. The Lead GP and other GPs are attending training in conjunction with nursing staff and the palliative care team to ensure that prisoners who are terminally ill receive effective pain relief. All staff in the inpatient unit will attend the introduction to end of life training by May 2015.	May 2015 Head of Healthcare

			At present, there are five staff trained.	
4	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	All prisoners who attend outside appointments have a risk assessment completed on them prior to leaving the establishment. The risk assessments are reviewed and updated when situations change to reflect the latest medical information and the required level of restraints required. The only exception to local authority making these changes is for Category A prisoners and above. Any changes to their restraints will be authorised by the Deputy Director of Custody and this will be based on medical information balanced against security risks to the public.	Completed The Governor Head of Healthcare