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 Preston

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 pancreatic cancer in July 2014 at HMP Preston. He was 77 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Wymott and HMP Preston was undertaken. Both prisons cooperated with the investigation.

The man received a sentence of three years and eight months in prison on 15 February 2013 and went to HMP Liverpool. He had an existing diagnosis of Alzheimer's disease for which he was prescribed medication. In April 2013, he transferred to a specialist wing for elderly and infirm prisoners at Wymott.

In March 2014, the man spent some time in hospital. Afterwards, he became increasingly jaundiced and blood tests were abnormal. In April, a prison GP referred him urgently to hospital with suspected cancer. He was subsequently admitted to hospital and tests revealed that he had pancreatic cancer, which had spread to his liver. His condition was not curable. The hospital discharged him to Wymott on 20 May and, on 22 May, he moved to the inpatient unit at HMP Preston for palliative care. He received good care at Preston and died peacefully in July.

I am satisfied that the man received appropriate clinical care in the prison, equivalent to that he could have expected to receive in the community. However, the investigation identified a need for improvements at Wymott, which remained responsible for him after his admission to the inpatient unit at Preston, an arrangement which does not appear to work effectively. I am concerned that restraints were used without a properly considered risk assessment, when he went to hospital, a matter I have raised with Wymott a number of times before. An application for compassionate release was not given sufficient priority and there was an unacceptable delay in informing his partner of his death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2015**

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SUMMARY

1. The man arrived at HMP Liverpool on 15 February 2013 after being sentenced to three years and eight months in prison. He had been diagnosed with Alzheimer's disease and took medication for high blood pressure, high cholesterol and angina. On 29 April 2013, he transferred to a wing for elderly and infirm prisoners at HMP Wymott.

2. On 13 March 2014, the man was admitted to hospital, after suffering cardiac failure and a bleeding ulcer. The hospital discharged him on 21 March. After he returned to the prison, healthcare staff noted that he looked increasingly jaundiced. Prison doctors referred him for blood tests, which were abnormal. On 14 April, a prison GP referred him to a specialist urgently, with suspected cancer.

3. On 25 April, a specialist reviewed the man and admitted him to hospital for investigations. A CT scan revealed undiagnosed pancreatic cancer, which had spread to his liver. Doctors did not consider active treatment was possible and arranged palliative care. Staff explained the diagnosis to him and his partner on 9 May and the hospital discharged him on 20 May. He returned to Wymott that day.

4. On 22 May, the prison arranged for the man to transfer to the palliative care suite at HMP Preston, as Wymott did not have the facilities for continuous care. Healthcare staff at Preston nursed him using a comprehensive care plan and liaised closely with community palliative care services. He and his partner were actively involved in decisions about his care

5. From 4 July, the prison agreed to leave the man's door open at all times, to allow nurses ready access to care for him. As his condition deteriorated, healthcare staff ensured he received appropriate pain relief and other medication to control his symptoms.

6. A nurse was at his bedside when he died a few days later. At 6.40am, Preston informed Wymott (which retained administrative responsibility for him) of his death. Wymott did not have a family liaison officer available to inform his family and made no other arrangements. A nurse at Preston, who came on duty at 8.30am, was concerned that Wymott had still not informed his partner of his death and, after getting permission from Preston's duty governor, rang his partner to let her know he had died.

7. We are satisfied that the man received good medical and nursing care in prison. However, we are concerned that he was restrained without a fully considered risk assessment when he went to hospital. There were delays in compiling an application for compassionate release and in informing his partner of his death. We make three recommendations to the Governor of Wymott.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Preston and HMP Wymott informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He wrote to the Governor of HMP Wymott about the preliminary findings of the investigation, as the concerns related to Wymott's responsibilities.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at Wymott and Preston.

11. We informed HM Coroner for Preston and West Lancashire District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's partner, his nominated next of kin, to explain the investigation. She had the following questions which she wanted the investigation has taken into account:

    - Was there was a delay in his diagnosis after he returned to prison from hospital in March 2014, when me he was clearly jaundiced?
    - Did being in prison adversely affect his chances of receiving treatment for the cancer?
    - Did he receive the correct medication and monitoring?
    - What happened when he died and why was there a delay in informing her?

    All of her questions were addressed in separate correspondence.

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

HMP PRESTON

14. HMP Preston is a local prison holding up to 842 adult men. Health services are provided by Lancashire Care Foundation Trust. There is an inpatient unit for up to 30 prisoners which is used as a regional facility including for end of life care. In-patients remain the responsibility of their original prison for all aspects except healthcare.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Preston was in April 2014. Inspectors found that healthcare overall was safe and decent. The inpatients unit provided patients with complex needs with good support. However, some aspects of the environment and regime needed improvement. Inspectors noted that end-of-life care was provided in the prison's inpatient unit. The nursing care reflected gold standard guidance and was very good. A local end-of-life and palliative care policy was being finalised.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to March 2014, the IMB noted that the primary care team at Preston ran a large number of services and provided a wide range of care including to prisoners referred from other prisons in the region. The IMB noted that as a result there were a number of deaths through natural causes. The IMB considered that the staff provided good end of life care, which was at least as good as that in the community.

Previous deaths at HMP Preston

17. The man was the tenth prisoner to die of natural causes at HMP Preston since the beginning of 2013. Preston has a regional inpatient service which takes prisoners with complex health needs and who need end of life care from other prisons in the area.

HMP WYMOTT

18. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24 hour nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Wymott was in July 2014. Inspectors found that there was excellent care for older prisoners and those with disabilities held on the specialist facility in I wing. The quality of health care was reasonably good, but undermined by long delays and poor access to GPs and the dentist. The range of clinics provided reflected the needs of the prison population and including for chronic diseases. There were good palliative care and end of life procedures.

Independent Monitoring Board

20. In its most recently published report for the year to May 2014, the IMB noted that waiting times for GP appointments was an issue, but the IMB noted that the triage system operated by the nurse-practitioner had ensured that urgent cases were seen promptly. They commented that management and staff have worked hard to maintain Wymott as a prison that holds prisoners with safety, decency, respect and security. The IMB noted that there were two full time carers on I wing and several cells had been modified to accommodate prisoners with specific care needs.

Previous recommendations

21. We have made previous recommendations to Wymott about the inappropriate use of restraints for elderly and infirm prisoners.

ISSUES

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

22. The man was sentenced on 15 February 2013 and went to HMP Liverpool. He had been diagnosed with Alzheimer's disease a month before for which he took medication. He also took medication for high blood pressure, high cholesterol levels and angina. On 5 April 2013, he transferred to HMP Wymott.

23. In the spring of 2014, the man's physical health began to deteriorate and on 13 March he complained of chest pain. He was admitted to hospital and doctors diagnosed cardiac failure and a bleeding duodenal ulcer. After treatment, the hospital discharged him to Wymott on 21 March. A discharge letter advised about his ongoing care, including an appointment for cardiac tests and a gastroscopy. Healthcare staff at Wymott monitored him in line with the guidance in the discharge letter.

24. On 26 March, a nurse noted that the man was slightly jaundiced. She listed him for a blood test on 2 April and referred him to a doctor. On 2 April, a prison GP noted he still appeared jaundiced. The blood test results, received on 4 April, were abnormal, and another prison GP carried out a viral hepatitis screening test that day. Nurses chased up the test results with the pathology laboratory the next week, but there is no note of the results in his record.

25. A GP examined the man again on 14 April and referred him to a gastrology clinic (under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks), as he was concerned about the possibility of pancreatic cancer. The doctor took further blood tests on 16 April, which indicated that he had high iron and B12 levels (which can indicate liver disease). A nurse reviewed him on 22 April. She noted his increased jaundice and informed the doctor. As he had a scheduled gastrology appointment for 25 April, the doctor did not make a further referral.

26. The man attended the appointment at the hospital's oesophago-gastric clinic on 25 April and the hospital admitted him for further investigations. After a CT scan, a consultant oncologist diagnosed him with pancreatic cancer which had spread to his liver. His condition was beyond active treatment and the hospital arranged palliative care.

27. On 9 May, the oncologist and specialist hospital staff explained the diagnosis to the man and his partner. The hospital informed healthcare staff at Wymott on 12 May and discharged him on 20 May.

28. The clinical reviewer noted that when the man was discharged from hospital in March, his cancer had not been detected and prison healthcare staff had no reason to suspect it. Healthcare staff followed the hospital's discharge instructions for his heart condition and duodenal ulcer. The clinical reviewer considered that his care between 21 March and 25 April was consistent with his condition at the time.

29. Healthcare staff gave the man daily care after his discharge from hospital in March and he was eating normally and following his usual routine. Between 26 March and 14 April, prison GPs tried to establish the cause of his jaundice with blood tests. After these tests were complete, a doctor referred him promptly to a specialist. The clinical reviewer noted that this broadly comparable with what he would have experienced if he had been treated in the community. We are satisfied that there was no delay in referring him for suspected cancer or in his diagnosis.

The man's clinical care

30. After his diagnosis, the man transferred to Preston on 22 May, for palliative care. An oncologist at hospital saw him on 3 June and explained that chemotherapy was not possible because of his ongoing jaundice and frail condition. She considered that chemotherapy would threaten his remaining quality of life.

31. The clinical reviewer noted that the inpatient unit at Preston has a close working relationship with a local hospice. There is good clinical and management supervision, which reinforces good practice and ongoing multidisciplinary team meetings involving the hospice, community palliative care services and healthcare staff at Preston.

32. Nurses used a comprehensive care plan to care for the man. The plan included attention to pain relief, the care of potential pressure sore areas and incontinence. They liaised with community palliative care services and actively involved him and his partner in decisions about his care. His partner attended meetings with his consultant.

33. On 24 June, the man decided that he did not want to be resuscitated if he had a cardiac or respiratory arrest. A prison GP discussed the decision with him and recorded it in his medical record.

34. Doctors prescribed end of life medications (to control symptoms such as pain and nausea) which were available from 1 July. As his condition deteriorated, the man needed frequent nursing care. From 4 July, the prison left his door open to allow healthcare staff immediate access at any time. As he began to experience greater discomfort, he received appropriate pain relief.

35. A nurse looked after the man throughout the night before he died. She noted that he was suffering from discomfort at 7.30pm and gave him medication. She gave him further pain relief at 1.30am and 5.00am. She gave him mouth care (to keep his mouth and lips moist and comfortable) and repositioned him frequently throughout that night.

36. At 5.50am, the nurse noted the man's breathing had become rapid and shallow and he died peacefully at 6.05am. She was with him when he died.

37. We are satisfied that the man received high quality care in both prisons, and particularly good palliative and end of life care at Preston. The care planning, liaison with palliative care specialists and involvement of him and his partner, was good practice.

The man's location

38. From April 2013, the man lived on I wing at Wymott, a specialist wing for older, infirm and disabled men. He lived on the wing for almost a year and settled with no significant difficulties. After his diagnosis, Wymott did not have the facilities to care for him and he transferred to the inpatient unit at Preston. He said that if he could not be released from prison, he preferred to stay at Preston for his end of life care. We are satisfied that he was appropriately located throughout his illness.

Restraints, security and escorts

39. 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 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 takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and the risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also said that restraining a prisoner by handcuffs receiving chemotherapy (and by implication, other life saving treatment) was degrading and that this would be likely to be regarded as inhumane, unless justified by other relevant considerations.

40. Wymott did not provide all the risk assessments for the man's hospital appointments and admissions while he was there. The available risk assessments, including when he transferred to Preston, show that the prison considered he was a low risk to the public and of escape but a high risk to children because of the nature of his offence. Contributions from healthcare staff did not make clear whether his condition affected his ability to escape as the court judgement requires. Each time he attended hospital, two officers escorted him and restrained him by handcuffs or an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). A nurse often went with him.

41. When the man attended an oncology clinic appointment at hospital on 3 June, he was accompanied by two prison officers and a nurse. Staff did not use restraints.

42. The man was elderly and frail, suffered from Alzheimer's and was clearly unwell. His risk assessments indicated that he was low risk of escape yet

despite his condition, until 3 June, staff used restraints. The risk assessments did not include healthcare input about his risk, in line with the court judgement. We cannot therefore be satisfied that the use of restraints was justified by a fully considered risk assessment, a matter we have raised with Wymott a number of times before. We make the following recommendation.

The Governor and Head of Healthcare at Wymott should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, 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 family

43. During the final weeks of his life, a nurse and other staff from the inpatient unit at Preston supported the man's partner. His partner visited him in the inpatient unit at Preston, the day before he died and left at 4.45pm. She spoke to another nurse about his deterioration and said that the first nurse had assured her that someone would call her if his condition deteriorated significantly, so that she could come back to the prison. The first nurse agreed it was likely that she had said this. In the event, there was no significant change in his condition and he died peacefully, shortly after his breathing changed and before anyone could call his partner.

44. As the man was occupying a regional bed at Preston, he remained Wymott's administrative responsibility and it was Wymott's responsibility to inform his partner that he had died. The orderly officer at Preston informed Wymott at 6.40am. However, Wymott did not have a family liaison officer available and did not make alternative arrangements to contact his partner.

45. When the nurse came on duty at 8.30am at Preston that morning she was concerned that the man's partner had still not been informed of his death. She had supported her during his last weeks and, with the agreement of the duty governor, she telephoned his partner at about 9.00am and informed her that her partner had died.

46. The man's partner was distressed that she was not called until three hours after he had died as she had expected to be informed of any deterioration in his condition. We are satisfied that it was not possible for Preston to call her before he died, as his death came very quickly. However, we are concerned that Wymott did not give priority to notifying her after his death.

47. Prison Service Instruction (PSI 64/2011) states:

> "Wherever possible, the family liaison officer and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source."

48. We do not consider that the arrangement for previous prisons to retain responsibility for dying prisoners who are admitted to Preston's healthcare inpatient unit are entirely satisfactory. The delay in informing the man's partner of his death is an example where this did not work effectively. However, Wymott was responsible, and the lack of a family liaison officer was not a good enough reason for the unacceptable delay in informing his partner of his death. A manager at the prison should have done this. We make the following recommendation:

The Governor of Wymott should ensure that a member of Prison Service staff informs the prisoner's next of kin quickly and in person of their death, in line with national guidance.

49. Wymott later appointed a prison chaplain as their family liaison officer. He phoned the man's partner at around 10.00am on 8 July and offered condolences and support. He visited her at home on 10 July.

50. The funeral was on 31 July. Wymott arranged the funeral and met the cost in line with national guidelines. The deputy governor and the chaplain attended.

Compassionate release

51. Release on compassionate grounds is a means by which seriously ill prisoners, usually with a life expectancy of less than three months, can be released from custody before the end of their sentence. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

52. Soon after the man's terminal diagnosis, on 13 May, while he was still in hospital, the older person's lead at Wymott made initial enquiries about compassionate release for him after discussing the possibility with him and his partner.

53. On 4 June, a nurse at Preston completed a referral for assessment of a life limiting condition to a hospice. She noted that the man's life expectancy was less than six months, but the prison did not make an application for compassionate release at the time.

54. On 19 June, a prison GP completed the medical section of an application for compassionate release. His prognosis was that the man had six weeks left to live. Probation assessments were completed on 23 and 24 June. The Governor submitted the application, which was faxed to PPCS just before 6.00pm on Friday 4 July. The PPCS had not made a decision before he died.

55. We are satisfied that compassionate release was appropriately considered and discussed with the man and his partner. However, we consider the process should have begun earlier when he was first diagnosed. Once an application was started on 19 June, we are concerned that it took over two weeks to submit it, although a GP had indicated only a six-week prognosis. The application should have been progressed and submitted quickly. We make the following recommendation:

The Governor of Wymott should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that they are submitted without delay.

RECOMMENDATIONS

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

2. The Governor of Wymott should ensure that a member of Prison Service staff informs the prisoner's next of kin quickly and in person of their death, in line with national guidance.

3. The Governor of Wymott should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that they are submitted without delay.

ACTION PLAN

No	Recommendation	Accepted / Not Accepted	Response	Target date for completion & Function Responsible
1	The Governor and Head of Healthcare at Wymott should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, 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	Head of Healthcare to remind all Healthcare staff of the legal position in 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. A Governors Order (05/2014) was issued in September 2014. The order instructs staff to ensure that the new escort risk assessment forms are used with immediate effect when completing all escort risk assessments. The hospital escort risk assessment states: “A new risk assessment is required for every escort / appointment”. The Healthcare section within the assessment records the current condition and risks posed of a prisoner. Seek a protocol with HMP Preston giving consideration as to whether they use a Wymott escort risk assessment, or whether it is practical to have Wymott undertake the risk assessment.	31/12/14 Head of Healthcare Completed Governor of Wymott 31/12/14 Head of Safer Prisons
2	The Governor of Wymott should ensure that a member of Prison Service staff informs the prisoner’s next of kin quickly and in person of their death, in line with national guidance.	Accepted	Where possible an operational Governor will undertake this task with the relevant appointed Family Liaison Officer as soon as possible. If a death is sudden a FLO will be appointed at the earliest opportunity and the next of kin will be informed face to face wherever possible by a Senior Manager without delay.	Completed and ongoing Governor of Wymott

3	The Governor of Wymott should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners and that they are submitted without delay.	Accepted	A flow chart will be produced which outlines the process for considering release on compassionate licence, at the earliest opportunity.	31/12/14 Head of Offender Management