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 at Wheatfields Hospice while in the custody of HMP Leeds, on 15 July 2012

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 report of an investigation into the circumstances surrounding the death a man, a prisoner from HMP Leeds, at Wheatfields Hospice, on 15 July 2012. The man, who was 61 years old, died from metastatic cancer, heart disease and chronic obstructive pulmonary disease. I offer my condolences to the man's family and all those affected by his death.

The investigation was carried out by an investigator for the Prisons and Probation Ombudsman. A clinical reviewer conducted a review of the man's clinical care, on behalf of Leeds Community Healthcare Trust. HMP Leeds cooperated fully with the investigation.

The man was in poor health with a number of ailments before he was sentenced to prison in 2009. Following a diagnosis of terminal bladder cancer in March 2011, he was admitted to Leeds prison healthcare centre where he received palliative care. His condition deteriorated and on 13 July 2012, he was released on temporary licence to Wheatfields Hospice in Leeds, where he died two days later.

Overall, I am satisfied that the prison provided a very good standard of care for the man, which was at least equivalent to that which he could have expected in the community. The prison adopted a generally compassionate approach which allowed the man to die with dignity, although it is disappointing that restraints were used on him during one hospital treatment without appropriate justification.

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 2013**

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SUMMARY

1. The man was sentenced to 17 years imprisonment on 6 February 2009, at Leeds Crown Court for sexual offences. He was taken to HMP Leeds the same day. He was 58 at the time.

2. The man had a number of existing medical conditions, including osteoarthritis in the neck, spine, knees and shoulders, chronic obstructive pulmonary disease, cirrhosis of the liver, and there was concern about heart disease. He also had limited mobility and used a walking stick.

3. The man was discovered to have a prostate condition on 8 April 2010, after a routine test and consultation with one of the prison doctors. Following a referral to secondary care and a biopsy, cancerous cells were found in his bladder. Initially, it was believed that the cancer had been discovered early and would respond to treatment. The man's prognosis at that stage was positive.

4. Secondary care providers devised a treatment plan involving a series of surgical procedures, and a form of radiotherapy. On 29 November 2010, during planned surgery, it was discovered that the man had developed a mass in the lower part of his large intestine. After exhausting all treatment options a prison doctor told the man on 20 April 2011 that his cancer had spread and was incurable. The man remained at Leeds and attended hospital appointments for secondary care and was occasionally admitted to hospital as an inpatient.

5. The man was released from Leeds on temporary licence to Wheatfields Hospice on 13 July 2012, accompanied by a prison officer in civilian clothing. His family were able to visit him and were kept informed of his condition. The man's health deteriorated rapidly and he died on 15 July 2012. His family were notified promptly and funeral expenses were offered. The cause of death was recorded as metastatic carcinoma, ischaemic heart disease and chronic obstructive pulmonary disease

6. The investigation found that the care given to the man was both timely and appropriate, and at least the equivalent of that expected in the community. Although he received a good standard of care, we are concerned that restraints were used while he was seriously ill, including when he was undergoing a blood transfusion. We have made a recommendation about this.

THE INVESTIGATION PROCESS

7. Notices were issued announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward as a result.

8. Following a delay, due to administrative issues at the prison, the investigator received the documents relating to the man's time in custody. The investigator visited Leeds on 5 September 2012, and interviewed four members of staff. Further information was sought in writing from a fifth member of staff. The investigator subsequently wrote to the Governor to give preliminary feedback on the findings of the investigation.

9. Leeds Community Healthcare NHS Trust asked a clinical reviewer to review the man's clinical care on their behalf. He was provided with all relevant documentation to assist his review.

10. The investigation report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers wrote to the man's family at the start of the investigation, to explain the investigation process and invite comments or concerns about his care. She did not receive a response.

12. 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 LEEDS

13. HMP Leeds, in West Yorkshire, is a local prison holding up to 1120 male sentenced and remand prisoners.

14. Healthcare services are commissioned by NHS Leeds and provided by Leeds Primary Care Trust. During the day there is full healthcare cover, including a doctor, while at night there is nurse cover. There is an inpatient unit of six beds, recently reduced from 16.

HM Inspectorate of Prisons (HMIP)

15. HMIP last inspected Leeds in March 2010. The prison was found to have improved in the three areas, respect, safety and purposeful activity, that had caused particular concern in the previous inspection in 2007. It was also noted that the relationships between staff and prisoners had improved significantly. Healthcare was judged to be clean and tidy, but not an ideal environment. Primary care was said to be delivered well by the mix of officers and healthcare staff. Inspectors noted that the Liverpool end of life care pathway had been used for palliative care purposes and there were links to a local hospice where patients in the terminal stages of illness could receive care.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and humanely. In its most recent report, for the period January to December 2011, the IMB at Leeds reported favourably on the healthcare provided. The Board also noted that plans to reduce the services provided in the inpatient unit which would result in more serious health conditions being treated in hospital.

Previous deaths at Leeds

17. We have investigated a number of deaths at Leeds. There have been four since January 2011, of which the man's death was the fourth. One of these deaths was due to significant long-term medical conditions, the other two were self-inflicted. Our report into the death of the prisoner, who like the man was suffering from a long term medical condition, generally reflected well on Leeds. The investigation recommended that consideration be given to ensuring staff are clear about information relating to the National Institute for Clinical Excellence. There are no similar concerns in this investigation.

ISSUES

The diagnosis of the man's terminal illness

18. On 6 February 2009, the man was convicted of sexual offences and sentenced to 17 years imprisonment. He had no previous convictions and was sent to HMP Leeds. An initial health screen noted that he suffered from arthritis in his neck, spine, shoulders and knees and that he needed a walking stick to assist his mobility. A prison doctor recorded that, according to the man, he had undergone a liver biopsy the previous year but had no information about the results. The doctor requested the results of the biopsy tests as well as the man's medical history from his home GP.

19. The community medical records revealed a number of pre-existing medical conditions. These included chronic obstructive pulmonary disease (COPD - the name for a collection of lung diseases including chronic bronchitis and emphysema), cirrhosis of the liver (scarring due to long-standing injury, most commonly due to excess alcohol consumption) as well as concerns about ischaemic heart disease and high blood pressure. He had also been diagnosed with osteoarthritis in his hips and knees, which led to reduced mobility.

20. In March 2010, one of the prison doctors carried out a series of routine tests on the man. His prostate antigen level, which can be an early indicator for prostate cancer, was normal. On 8 April 2010, the doctor noted that the man had significant urinary symptoms, for which he prescribed tamsulosin (a drug to relax the smooth muscle in the prostate gland). The doctor subsequently found that the tamsulosin had been unsuccessful and made a referral to the urology clinic at Seacroft Hospital in Leeds.

21. The man was seen at the urology clinic on 21 July 2010. He was given further prostate tests, which showed an early indication of cancerous cells. On 30 July 2010, doctors at the department of urology in St James's University Hospital, Leeds, decided that the man would be an ideal candidate for a SABRE 1 trial (a feasibility study of internal radiotherapy and a prostatectomy - removal of all or part of the prostate gland). The referral for surgery was made by the consultant urologist on 20 September 2010 and took place on 29 November 2010. During the procedure, the surgeon discovered a recto sigmoid mass. (The recto sigmoid is the part of the large intestine that meets the rectum.) The operation was terminated and a referral was made to the colorectal department at Leeds General infirmary. The man's case was discussed by this department on 13 December 2010.

22. A consultant general and colorectal surgeon at Leeds General Infirmary, reviewed the man on 21 December 2010. At this consultation, the consultant surgeon referred him for a bladder cystoscopy (a surgical procedure in which a thin tube with a light and a camera are inserted to examine the bladder).

23. On 1 February 2011, the man was referred for surgery to remove a section from the lining of the bladder tumour, to send for analysis. The operation took

place on 24 February 2011, and it was then discovered that the man had a muscle invasive tumour – bladder cancer.

24. When it became clear that the man's prostate condition was getting worse, he was referred to secondary care promptly and at the appropriate time. We conclude that the diagnosis of the man's illness was managed appropriately.

Informing the man about his condition and treatment

25. A doctor saw the man on 29 March 2011 and noted that he had a 'frank conversation' with him about his condition and the merits of chemotherapy. He told him that chemotherapy only had a five per cent chance of being of benefit to him. In his opinion, given the man's level of fitness and the degree of his symptoms, the risks posed by undergoing a course of chemotherapy outweighed any possible benefits. The man declined chemotherapy. The doctor considered that only radical surgery would be beneficial at this stage. On 19 April 2011, in preparation for this procedure, the man had a CT scan in which it was discovered that he had a 13 millimetre lymph node in his pelvis. He was referred to a locum consultant in clinical oncology at Leeds General Infirmary for consideration of radiotherapy.

26. On 20 April 2011, after receiving the results of the CT scan, a prison doctor saw the man and told him that the results indicated that his cancer had spread, his prognosis was now much worse than previously expected and any further treatment would be palliative not curative. The doctor said that the man took the news 'philosophically'. A doctor saw the man on 25 May 2011 and explained that he would be treated by palliative radiotherapy, aimed at symptom control rather than cure.

27. On 11 July 2012, the man discussed with a nurse and a senior nurse his wish to sign a "do not resuscitate attempt cardiopulmonary resuscitate" (DNACPR) form. This gives a terminally ill patient the opportunity to note formally their wish not to be revived, or given advanced life support, in the event of either a cardiac or respiratory arrest. Later that day, after further consultation with healthcare staff, the man signed the DNACPR form. This was noted on his clinical record and the appropriate agencies were informed.

28. The man was initially seen about prostate problems on 8 April 2010. He was able to discuss his diagnoses with a doctor and other members of the prison's healthcare staff whenever he felt it necessary to do so. We are satisfied that the man was promptly and fully informed of both the progression of his illness, and the treatment options that were available to him.

The man's medical appointments and treatment

29. The man attended all his appointments for secondary care and was occasionally admitted to hospital as an inpatient. On 23 May 2011, a doctor noted that the man was suffering from bladder and urethral pain when passing urine and there had been a delay in his hospital outpatient appointment for

this condition. The doctor intervened and healthcare staff liaised with secondary care providers so he was seen the following day.

30. On 6 June 2011, the man was admitted to hospital as an in-patient for three days due to probable clot retention in his bladder, which caused him difficulty when passing urine. During his radiotherapy treatment, the man had to attend hospital daily over a three-week period between 23 June and 13 July 2011. These appointments were well coordinated by the prison.

31. On 7 March 2012, a doctor examined the man after he had complained of increasing pain in his pelvis. The doctor discovered a 'hard craggy mass' and immediately liaised with another doctor about possible treatment options. The other doctor advised that, unfortunately, there were no further chemotherapy or radiology options left.

32. On 9 March 2012, the man saw a clinical nurse specialist based at Wheatfields Hospice in Leeds who acted as the man's dedicated Macmillan nurse for the remainder of his illness. The nurse specialist saw the man on 12 March, and then regularly during the remainder of his illness. She was available, throughout, to offer support and advice to the man and the healthcare staff at Leeds.

33. On 19 June 2012, the man attended Leeds General Infirmary to undergo a surgical procedure on his bladder and also a blood transfusion. His return to the prison was delayed because of concerns about his blood tests. He was discharged on 25 June 2012.

34. The clinical reviewer considers that the liaison between the prison and secondary care providers was very good. Following diagnosis, and throughout emergency and planned admissions to hospital, the level of contact between the prison healthcare and hospital staff was considered to be good. The clinical reviewer's assessment is that the management of the man's care in prison was at least equivalent to that he would have expected to receive in the community and notes:

> "There were no unnecessary administrative delays throughout the course of the man's last illness and HMP Leeds Healthcare Department could not have anticipated this disease. I can find no shortcomings in how the man was managed whilst serving his sentence at HMP Leeds"

35. Given the nature of the man's illness much of his treatment was administered by external specialists. A doctor, and the healthcare staff, coordinated his care and treatment effectively. All actions were appropriately documented in the medical records and it is clear that staff were thorough in following up treatments. The clinical reviewer is satisfied that the man's care was appropriate to his needs, and we agree.

The man's pain relief and medication

36. In November 2010, when the man's illness was in the early stages, his pain relief was initially managed with Tradorec, (an opiate-based pain killer for moderate to severe pain). By March 2011, his medication had been changed to 100mg of a morphine sulphate-based pain killer. On 21 April 2011, this was increased to 120 mg.

37. By 24 June 2011, the man's morphine dose had been increased to 900 mg daily, with an additional 150 mg to be taken as required for breakthrough pain. A course of radiotherapy was started in an attempt to control the man's pain and reduce the size of his tumour. Initially, this had a positive effect and his daily dose of morphine was reduced. By 8 August 2011, the daily dosage had been reduced to 300mg.

38. The radiotherapy treatment did not have the desired effect. In April 2012, the man's dosage of morphine was 1200 mg with a further 140 mg of liquid morphine available to him for breakthrough pain. A doctor commented that despite the man's obvious pain and discomfort he was fully mobile and maintained a healthy appetite.

39. The man's oral morphine medication was subsequently changed in favour of a Fentanyl patch. This delivered an opiate-based pain killer directly through the skin.

40. The clinical reviewer identified one area of concern in relation to the man's medication. On 15 May 2012, following his discharge from an extended stay in Leeds General Infirmary for examination of his abdomen, the man was reported to be suffering from visual hallucinations and behaving out of character. When a doctor investigated, he found that while in Leeds General Infirmary there had been an error in prescribing the man's morphine at the hospital.

41. A doctor explained to the investigator that before the man went into Leeds General Infirmary he was on a prescription of 1200 mg of MXL daily (a morphine sulphate painkiller). On arrival at Leeds General Infirmary, hospital staff misinterpreted this prescription and reduced the dosage to 150 mg. The man continued on this prescription of MXL until his discharge from hospital. It was noted on the discharge summary that there had been 'no intentional changes to his medication'. Healthcare staff who processed the man on his return to the prison prescribed him the MXL dose that he was on before his admission to hospital, ie 1200 mg. The increase from 150mg to 1200mg of MXL therefore caused the man to suffer over opiation. This error was attributable to the hospital and does not come within our remit.

42. On 1 June 2012, the man told a doctor that he was in considerable pain despite the use of the fentanyl patch. By 27 June, the strength of the patch

had been increased. In addition, the man was also prescribed 200 mg of liquid morphine every four hours as required.

43. The man's medications were well administered by healthcare staff. As his condition deteriorated, anticipatory medication was ordered for use with a syringe driver (a small, lightweight, battery powered pump which administers pain relief under the skin). We are satisfied that the man's pain relief was well managed. He was given pain relief medication as required and healthcare staff were responsive to his needs, changing the method of administering medication as his condition changed.

Liaison with the man's family

44. A nurse at Leeds was appointed as the man's family liaison officer (FLO) shortly after his diagnosis. The FLO and the man had long conversations about his illness, his family and his wishes for his funeral arrangements.

45. On 13 July 2012, the man was released on temporary licence to Wheatfields Hospice. A prison officer in civilian clothing remained throughout to provide support for the man and his family. The FLO contacted the man's family members with an update on his condition and offered them the opportunity to visit him that day. His family initially accepted the offer, but then asked if they could visit the following day, 14 July 2012, instead. The FLO agreed to this and arranged for a taxi to collect the man's family, and take them home. The FLO contacted the man's family after their visit and he reported the family as being 'of sombre mood but grateful'.

46. The man's family visited him again the next day. However, shortly after they left, he died. They immediately returned to the hospice after they were informed of his death. The FLO arranged for a taxi to collect the man's daughter, who was not with the rest of the family.

47. The man's funeral took place at Pontefract Crematorium on 3 August 2012. Leeds met the funeral expenses.

48. The FLO kept a detailed record of his contact with the man's family and we consider that he undertook this role well. The practical aspects of his liaison, such as arranging transport for his family to visit him, shows a caring and sensitive approach. We consider that the man's family were well supported by staff at Leeds.

The man's location

49. When the man went into Leeds on 6 February 2009, he was given a cell on A wing, which houses vulnerable prisoners. These are prisoners who are segregated from the general prison population for their own protection, usually because the nature of their offence makes then vulnerable to intimidation from other prisoners. On 14 April 2011, as his illness

progressed and he required more care, he was admitted to the prison's healthcare wing, H3, as an inpatient.

50. The man found it increasingly difficult to remain on H3. On 19 August 2011, he asked a doctor if he could return to A wing where he had a better support network of friends enabling him to cope better with his illness and prognosis. The doctor agreed as long as he could have a single cell. A suitable cell became available on 28 October.

51. The man remained on A wing until 25 June 2012, when after an extended stay in Leeds General Infirmary for a blood transfusion and surgery on his bladder the man returned to H3 because of his deteriorating condition.

52. The man had a minor fall in his cell during the night on 11 July 2012, so healthcare staff decided to leave his cell door unlocked overnight. This allowed them immediate access to him at all times if he required assistance. The man remained on H3 until his condition further deteriorated and on 13 July 2012, he was taken by ambulance to Wheatfields Hospice where he died two days later.

53. We are pleased to note that good efforts were made to enable the man to remain on the location of his choice for as long as practicable.

Compassionate release

54. Early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is only granted in exceptional circumstances. The decision to release a prisoner on compassionate grounds is made by the Secretary of State but the Governor can grant release on temporary licence (ROTL). When diagnosed with terminal cancer, the man discussed the possibility of compassionate release with a doctor, or failing this, a release on temporary licence.

55. The man subsequently applied to be considered for compassionate release. This was refused on the grounds of the nature of his offence, his risk to the public and the length of custodial time that he had served, balanced against the length of sentence remaining. Instead, it was decided that the man should be released on temporary licence when he was admitted to Wheatfields Hospice.

Palliative care plans

56. The man's illness was managed by his Macmillan nurse under the guidelines of the Gold Standard Framework (GSF) for cancer care. (The Gold Standard Framework is a systematic approach to improving the quality and organisation of care for patients nearing the end of their life in any setting). The Macmillan nurse and a doctor spoke at length to the man and ensured that he fully understood the progressive nature of his cancer. The clinical reviewer notes:

> "The healthcare department at HMP Leeds liaised at the appropriate times with Secondary care agencies including Macmillan nurses and Wheatfield Hospice throughout his illness".

57. In addition to medical needs, a doctor assisted with provision for the man's spiritual needs. On 28 May 2012, he arranged for the Anglican chaplain to spend some time with the man, which he found to be of great comfort. The doctor also arranged for one of the man's friends from his residential wing to visit him while he was on H3. Again, the man found this to be of comfort at a difficult time.

58. On 11 July 2012, the GSF palliative care plan was put into place to ensure that the man was comfortable and had adequate pain relief in the terminal stages of his illness. The Liverpool Care Pathway for the Care of the Dying, was started on 14 July, at Wheatfields Hospice. (The Liverpool Care Pathway is a nationally recognised plan to manage the care of patients in accordance with their wishes, in the last days or hours before their death.)

59. The man's medical records show that there was clear and consistent communication between prison healthcare staff, external hospital staff and the Macmillan nurse. Timely palliative care was put in place and staff were responsive to the man's needs in accordance with the agreed care plan.

Restraints, security and bed watch

60. 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.

61. 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 those risks posed by the same prisoner when suffering from a serious medical condition. The judgment 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.

62. The man attended a number of external hospital appointments, on some occasions as an inpatient. The escort documents show that officers used standard handcuffs for journeys and an escort chain while he remained in hospital. (An escort chain is a single handcuff attached to the prisoner, a length of chain then connects this to another handcuff worn by an officer). On 19 June 2012, the man was taken to hospital for a blood transfusion. The

record of events for that visit indicates that he remained on an escort chain while undergoing this procedure and officers did not telephone the prison to gain permission to remove his restraints.

63. Prison staff conducted risk assessments for the hospital journeys, including brief input from healthcare staff. The assessments covered risk to the public, risk of hostage taking; escape potential (including the likelihood of outside assistance to aid escape); risk to females and risk to hospital staff. The man was assessed as a medium risk to the public but in all other areas he was considered to be low risk. Despite the low level of risk, as well as recognition that the man was 'very ill' and required the use of a wheelchair, escort officers were advised that restraints were not to be removed for medical emergencies.

64. In view of the level of perceived risk, as well as the man's state of health and lack of mobility, we do not consider that the use of restraints was justified or appropriately balanced security with humanity. Two escorting officers should have been sufficient for security purposes. It was unnecessary to subject a dying man to the indignity of having to undergo procedures, such as a blood transfusion, while chained to an officer. We make the following recommendation.

The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time and that, unless there are wholly exceptional circumstances, restraints are not used during serious medical treatment.

CONCLUSION

65. The man arrived at Leeds with pre-existing medical conditions. His cancer was appropriately diagnosed and, as his condition deteriorated, prison healthcare staff provided a high standard of care. He was kept fully informed about his treatment options and his views were taken into consideration at every stage. There were regular and well documented interventions from doctors and other healthcare staff as well as evidence of good liaison between healthcare staff and hospital specialists to ensure that he received appropriate treatment and medication. We agree with the clinical reviewer that the care that the man received while at Leeds was at least equivalent to that available in the community. However, we consider the use of restraints while undergoing medical treatment was not justified by the prison's own risk assessment process.

RECOMMENDATION

The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time and that, unless there are wholly exceptional circumstances, restraints are not used during serious medical treatment.

Accepted. "HMP Leeds will ensure risk assessments and restraints reflect the risk presented by a prisoner at the time of escort."