Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of a prisoner at HMP Wandsworth on 20 November 2014

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

This man died of throat cancer in hospital in November 2014. He was 67 years old. I offer my condolences to the man's family and friends.

The investigation found that there was a delay in diagnosing the man's cancer, although the clinical reviewer considered this did not affect the eventual outcome for him. It took too long to arrange a suitable diet and the prison did not fully take into account the man's security category and his terminal condition when assessing his risk for hospital appointments.

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 **September 2015**

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Summary

Events

1. On 30 March 2009, the man was sentenced to four and a half years in prison for possession of a firearm. In 2011 and 2013, he was sentenced to further time in prison. He had been at HMP Wandsworth since 17 December 2013.

2. The man suffered from a number of medical conditions including asthma, chronic obstructive pulmonary disease (COPD – a lung disease), back pain and acid reflux. He was a lifelong heavy smoker and smoked up to 140 cigarettes a day. Healthcare staff helped him to give up smoking and he stopped in 2013.

3. On 1 August 2014, the man reported problems with his teeth, which he thought were responsible for giving him headaches. On 3 September, he told a GP he had a swelling in his left jaw. The GP diagnosed a dental abscess and prescribed antibiotics. The man continued to experience pain and facial swelling, which he reported to nurses twice in mid-September.

4. On 17 September, a dentist examined the man and suspected his facial swelling was due to a cancerous tumour. He arranged for him to go to the accident and emergency department at outside hospital with an urgent referral to the maxillofacial department.

5. An oral surgeon at the hospital saw the man and recommended an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The hospital did not make the appointment until healthcare staff at Wandsworth chased. He eventually received one for 10 October. On 25 September, he moved to Wandsworth's inpatient unit for pain management.

6. On 20 October, the man was diagnosed with throat cancer and on 23 October a hospital oncologist told him that the cancer could not be cured and his condition was terminal. On 13 November, he was very unwell and a Macmillan nurse arranged his admission to hospital. His condition continued to decline in hospital and he died on 20 November, after suffering a cardiac arrest.

Findings

7. The investigation found that there was a delay in diagnosing the man's cancer. We are also concerned that it took too long to arrange a suitable diet for him and that the prison did not fully take into account the man's security category or health condition when assessing his risk for hospital appointments.

Recommendations

- The Head of Healthcare should ensure that prisoners who report on-going acute pain have their symptoms thoroughly examined and investigated urgently and that prisoners with suspected cancer are referred as two week urgent referrals, in line with NHS guidelines.
- The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.

- 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.

The Investigation Process

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

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. The investigator obtained copies of relevant extracts from the man's prison and medical records. The investigator and the clinical reviewer interviewed four members of staff at Wandsworth on 22 January. The investigator interviewed one prisoner by telephone on 16 March and two officers by telephone on 17 March. The clinical reviewer and another investigator interviewed a member of staff at Wandsworth on 29 January.

11. We informed HM Coroner for Westminster of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's daughter, who he had named as his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The man's daughter asked for the following matters to be considered: the length of time it took to acknowledge and diagnose the lump on the man's neck/face; how his care was managed, including medication, appointments and referrals and how the family were kept informed of his illness.

13. The man's family received a copy of the draft report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

14. The initial report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

15. 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 family, and whether compassionate release was considered.

Background Information

HM Wandsworth

16. HMP Wandsworth is a local prison in London and holds up to 1,877 men in eight residential wings, at fill capacity. St George’s Healthcare Trust provides healthcare services at the prison.

17. There is an inpatient unit for up to six prisoners (The Jones Unit), which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs. There is also a 12 bed mental health unit (The Addison Unit).

HM Inspectorate of Prisons

18. The report of the most recent inspection of HMP Wandsworth in March 2015 has yet to be published. However, we understand that inspectors found that healthcare staff had a robust system for identifying learning arising from deaths at the prison. At an inspection in 2013, inspectors found that all health services had improved since the previous inspection though there were still areas for development.

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 latest annual report, for the year to May 2014, the IMB reported that the improvements in healthcare noted in last year's report had been maintained. Additional funding had allowed the level of screening to be increased. However, there has been too much reliance on bank and agency nurses, unfamiliar with the prison. The rate of non attendance at healthcare appointments was high.

Previous deaths at HMP Wandsworth

20. The man was one of four prisoners to die of natural causes in 2014 at HMP Wandsworth. We have raised the issue of the unjustified use of restraints before.

Findings

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

21. On 30 March 2009, the man was sentenced to four and a half years in prison for possession of a firearm. Further convictions in June 2011 and May 2013, added six years to the time he had to spend in prison. He had been at Wandsworth since 17 December 2013. He had a number of health conditions, including chronic obstructive pulmonary disease (COPD), asthma, back pain and acid reflux.

22. Between April and July 2014, the man saw the dentist for a number of routine appointments. There is no evidence from the records that he complained of any jaw or neck pain or that he had any swelling.

23. On 1 August, the man told a locum GP that problems with his teeth were causing headaches. The GP prescribed paracetamol. There is no record that the man mentioned any swelling.

24. On 3 September, the man told a prison GP that his left jaw was swollen and painful. The GP diagnosed a dental abscess and prescribed antibiotics. When interviewed, he could not recall the consultation and there is little in the record to explain the reasons for the diagnosis.

25. On 7 September, an officer noted that the man was suffering with neck pain and had been finding it difficult to get a doctor's appointment. She made an application for an appointment on his behalf. On 11 September, a nurse referred him to see a doctor, when he said he had pain on the left side of his head and his jaw was swollen. On 14 September, he told a further nurse that he was suffering from headaches and had pain in the left side of his jaw. He said that the pain had started two months previously and pain killers did not relieve it. The nurse noted that he had a scheduled doctor's appointment for 15 October and that she would try and bring the appointment forward.

26. On 17 September, the dentist examined the swelling on the man's face, which he said had been there for ten weeks. He had numbness along the lower border of the swelling and he was finding it difficult to eat. The dentist noted that the swelling was not related to his teeth, was fixed and measured about five inches. He noted the man's history of smoking meant he was at high risk of oral cancer and suspected that the swelling was a cancerous tumour. He made an urgent maxillofacial (head and neck) referral, via the accident and emergency department at outside hospital and the man was taken there that day.

27. A maxillofacial senior house officer examined the man at the hospital on 17 September and was concerned about his condition. He made an urgent referral to a maxillofacial clinic, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

28. Officers took the man back to the prison but healthcare staff were not sure what had happened at the hospital because he did not have a discharge summary. A nurse phoned to chase this several times, but the hospital never sent it. On 20 September, a nurse in the hospital's accident and emergency department told

the prison nurse that the department had referred him to clinic under the 'two-week rule'. The prison received no written confirmation of this.

29. On 23 September, two nurses and a prison GP all chased outside hospital to try to find out what was happening with the man's referral. Later that day, the specialist's secretary told a nurse from the prison that the clinic had not received the referral and advised her to contact the accident and emergency department. The prison nurse called the department and a nurse rang back later and said that a referral for the man had been completed and sent to the maxillofacial clinic that day.

30. On 8 October, the prison healthcare department received an appointment for the man. The letter, dated 23 September, had originally been sent to the man's address in the community and redirected. The letter invited him to an appointment at the hospital's maxillofacial and day surgery unit on 10 October. He attended the appointment and was referred for further outpatient investigations.

31. On 15 October, Wandsworth eventually received a discharge summary, which had incorrectly been sent to the man's community GP, detailing the results of his appointment on 10 October. The letter included an appointment for him to attend the specialist's clinic on 12 October, which he had missed. On the same day, a letter was received, addressed to the man at the prison, with an appointment for 20 October.

32. On 20 October, the man had a CT scan and a biopsy of the mass on his neck. The results showed a metastatic squamous cell carcinoma (cancer) of the left tonsil. On 23 October, an oncologist told him that he had incurable cancer. His condition was terminal and any further treatment could only be palliative to treat the symptoms.

33. The clinical reviewer noted that it was unclear how the prison GP reached the diagnosis of a dental abscess when he examined the man on 3 September. He considered this might have been a missed opportunity to identify the neck mass and make an earlier referral. However, he noted that a referral at that stage would not have had a significant impact on the final outcome for the man.

34. On 17 September, when the man went to hospital, the hospital failed to make the onward referral until 23 September. This meant that it took over three weeks before he was seen on 10 October, rather than within the target of two weeks. The actions of the hospital are outside the remit of this investigation. The clinical reviewer commented that, while the dentist had commendably attempted to get the man seen quickly, it might have been preferable to have made a standard urgent cancer referral, rather than through the accident and emergency department.

35. While this might not have altered the outcome for the man, it is important that all symptoms are thoroughly examined to determine their cause and that referrals or suspected cancer are made at the earliest opportunity. The clinical reviewer noted that there was only a possible minor delay on the part of the prison in referring the man. However, we were concerned to note that, although he continued to experience pain after seeing the prison GP on 3 September, he was

unable to get a further GP appointment until 15 October. Had he not seen the dentist on 17 September, this would have potentially delayed a referral substantially. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who report on-going acute pain have their symptoms thoroughly examined and investigated urgently and that prisoners with suspected cancer are referred as two week urgent referrals, in line with NHS guidelines.

The man's medical treatment

36. On 25 September, the man moved to the inpatient unit at Wandsworth, the Jones Unit, to help manage his pain. A pain management care plan was created and staff monitored him regularly.

37. On 24 October, the day after the man was informed of his diagnosis, a Macmillan nurse, who specialised in head and neck cancer at outside hospital, called the prison. She was concerned that the man had appeared very unwell during the appointment. She faxed a written report confirming his diagnosis and test results. She outlined his health problems, which included vomiting, poor appetite, constipation, dehydration, difficulties swallowing and pain in his head. She asked someone to contact her to discuss alterations to his medication to alleviate his symptoms, as he was too unwell at the time for any other treatment, including palliative chemotherapy.

38. The clinical reviewer noted that the man had a serious and advanced cancer affecting his swallowing, which put him at risk of malnutrition, dehydration and aspiration pneumonia. He said that this type of cancer would be difficult to manage under any circumstances. However, he was satisfied that the clinical care the man received in the Jones Unit was caring, attentive and holistic. There were clear management plans and he was monitored several times a day. Healthcare staff liaised with the Macmillan nurses at outside hospital to seek their advice. He was also referred to a primary care mental health team nurse for support.

39. Healthcare staff encouraged the man to drink and eat and planned to reduce the risk of him inhaling food by recommending a pureed diet and fluid thickeners. However, we are concerned that, despite a number of requests, the man did not get the soft diet he needed, until the end of October. A prison GP had first asked for a soft diet on 2 October and this was not provided until 28 October.

40. The man's pain appeared to have been controlled adequately. Staff had some concern that he might have been under-reporting the pain he was in. However, his pain control was reviewed regularly and there appears to have been no prolonged episodes of uncontrolled pain.

41. An urgent case review, which the man and his family were due to attend, on 6 November was cancelled by the hospital, as the consultant was no longer available. This was rearranged for 13 November. That day, the specialist Macmillan nurse was concerned that the man appeared very ill and he was admitted to hospital. The clinical reviewer noted that this was a very sudden decline as there was no indication in his records of a deterioration in his condition

in the days before. On the morning of 13 November, his clinical observations, including blood pressure, pulse, temperature and oxygen saturation levels had all been normal.

42. The man's condition continued to decline in hospital and he died early on the morning of 20 November. The hospital informed the man's daughter, his next of kin.

43. The man's condition declined quickly after his diagnosis and he was not able to receive the palliative chemotherapy that was originally planned. His pain was managed appropriately and he received good nursing care. However, we are concerned that it took so long for him to receive an appropriate diet. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.

The man's location

44. On 25 September, healthcare staff moved the man to the inpatient unit at Wandsworth (the Jones Unit) to help manage his pain effectively. He remained in the unit until 13 November, when he was admitted to hospital. We are satisfied that he was accommodated appropriately at Wandsworth.

Restraints, security and escorts

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk 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.

46. The man attended hospital six times. For five of these, he was still mobile and was considered still to be a risk of escape. Managers authorised two officers to escort him using double handcuffs to restrain him. Double handcuffing means that the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like this man, the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision.

47. When the man went to hospital on 28 October, the medical section of the risk assessment stated that he was terminally ill, suffering a rapid decline and used a wheelchair. Despite this, a manager decided that the escort officers should use

an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and one to an officer).

48. The man was not restrained for his hospital appointment on 13 November. The appointment was to discuss end of life care, and healthcare staff requested that the prison should take into account his terminal condition on grounds of decency and dignity. It was agreed that restraints should not be used for this appointment and he was not restrained during his subsequent stay in hospital.

49. We are not satisfied that the use of double handcuffs was justified for journeys to hospital or that the risk assessment on 28 October fully took into account the man's declining condition and how it affected his 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 family

50. When the man was given his diagnosis on 23 October, a nurse informed his daughter. His family visited him in prison the next day.

51. On 2 November, the prison appointed a family liaison officer. He went to see the man to explain his role. On 5 November, he spoke to the man's daughter about his condition and terminal illness diagnosis and the possibility of compassionate or temporary release.

52. Plans were made for the man's family to attend his multidisciplinary appointment on 6 November, though this was cancelled by the hospital the evening before it was due to take place. His family were subsequently able to accompany him to the re-arranged appointment on 13 November.

53. The family liaison officer kept in contact with the man's family throughout his time in hospital. He contacted his daughter after her father's death and discussed the return of his property and funeral arrangements. The prison contributed to his funeral costs in line with national guidelines. We consider that family liaison arrangement were adequate.

Compassionate release

54. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

55. The prison submitted an application for compassionate release to the public protection casework section of the National Offender Management Service (NOMS) in November. We are satisfied that the prison appropriately considered the possibility of compassionate release, but recognise that there was very little

time between the man's diagnosis and his death. Unfortunately, a decision had not been reached by the time of his death.

Action Plan

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1.	The Head of Healthcare should ensure that prisoners who report on-going acute pain have their symptoms thoroughly examined and investigated urgently and that prisoners with suspected cancer are referred as two week urgent referrals, in line with NHS guidelines.	Accepted	The Head of Healthcare will develop a written ‘Standard Operating Procedure’ for Offender Healthcare Staff outlining the two week urgent referral process of dealing with prisoners with suspected cancer. This will be in line with NHS Guidelines. The Head of Healthcare will trial a new system of ‘embargo slots’ for GP appointments whereby a small number of appointment slots for each clinic will be made available one week prior to the clinic (for clinicians to be able to book in patients for the following week) to ensure a more timely follow up in response to presenting clinical need. This will be monitored via weekly primary care complex case meeting and via weekly outpatient review clinic meetings.	Target date for completion: 30 November 2015 Head of Healthcare	
2.	The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.	Accepted	The Head of Healthcare will write to all Offender Healthcare staff informing them about the learning associated with ensuring that staff provide an appropriate diet to prisoners with serious illnesses and are more persistent in their follow up work when it is identified that incorrect diets have been provided to prisoners. Healthcare will complete the documentation and liaise with the kitchen managers to monitor delivery of required diets.	Target date for completion: 31 July 2015 Head of Healthcare	
3.	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take	Accepted	All escort risk assessments are considered by the Head of Security and Intelligence or in their absence the Governor In-Charge of the prison at that time.	Completed Head of Security and	

	into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.		Consideration of this intelligence is done in conjunction with a healthcare professional's assessment of the individual's capability to escape based on their medical condition and current state of health. Written instruction on risk assessment of prisoners being escorted to hospital has been included in the relevant section of the Local Security Strategy. This ensures that all staff involved in prisoner escorts to hospital have the information available to them with regards to the security concerns and health needs of the prisoner, allowing for a more informed decision of the risk the prisoner poses and the level of restraints to be used (if any). A notice to staff has been published to this effect and these will be monitored via national audit processes and via the Head of Security management checks.	Intelligence	

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