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 HMP Wakefield in June 2013

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 prisoner at HMP Wakefield, who died of lung cancer on 24 June 2013. He was 62 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A clinical reviewer reviewed the man's clinical care in prison.

The man was diagnosed with inoperable lung cancer on 24 April 2013. The cancer had spread to his bones and liver cancer was detected three weeks later. No active treatment was possible and the man was admitted to the prison's healthcare centre for palliative care. On 24 June, he was found not breathing and without a pulse, and was pronounced dead at 8.10pm by a paramedic.

I have some concerns about the handling of risk assessments for hospital visits, about which the prison appear to have lost the records, the cancelling of an urgent hospital referral for tests without an explanation and poor liaison with the man's family after his death. However, in relation to his terminal illness, the clinical reviewer concluded that the man received appropriate care at the prison. I am satisfied that the staff at Wakefield looked after him well and that the man received a standard of healthcare at Wakefield that was equivalent to what would be expected in the community.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was sentenced to life imprisonment in November 2000 and taken to HMP Woodhill. It was not his first time in prison. He spent his entire sentence in high security prisons as a category A prisoner – the security category for prisoners whose escape would be highly dangerous to the public.

2. Medical records indicate that the man was in reasonable health until December 2012, when he was treated for a persistent cough. A doctor referred the man to a respiratory specialist who holds a monthly clinic at the prison.

3. On 12 February 2013, X-ray results indicated a swelling on the man's right lung. The respiratory specialist ordered more tests and a CT scan on 6 March. An appointment for these tests was arranged for 27 March but the prison cancelled the appointment and there is no recorded explanation. Two weeks later, the man was taken to hospital for his scan.

4. On 24 April, the respiratory specialist saw the man at Wakefield and told him he had inoperable lung cancer which had spread to his bones. The man was placed on a palliative care plan and prescribed pain relief. On 29 April, he transferred to the prison's healthcare centre for nursing care.

5. On 21 June, it was agreed that the man's cell door should be left open at all times to allow healthcare staff easy access. An end of life care plan was started in the afternoon of 24 June. Five hours later, a nurse noted that the man had stopped breathing and she could not find a pulse. She called an ambulance and, at 8.10pm, a paramedic confirmed that the man had died.

6. The clinical reviewer concludes that the man received a satisfactory level of healthcare in custody.

7. We are concerned that the prison could not find the man's escort risk assessments for hospital visits so we have been unable to assess whether the man's security risk was appropriately balanced with his medical condition. The prison could not explain why the man's scan appointment was cancelled on 27 March which delayed the diagnosis of his terminal illness. After the man's death, the prison did not follow Prison Service guidance for breaking the news to his family and used the police, rather than a member of prison staff. No one from the prison contacted the man's brother until several weeks after his death.

THE INVESTIGATION PROCESS

8. The investigator issued notices informing staff and prisoners of the investigation and asking anyone with any relevant information to contact the Ombudsman's office. One response was received from a prisoner, but he then declined to speak to the investigator.

9. The investigator obtained copies of the man's relevant medical and prison records, with the exception of escort risk assessments. On 4 September 2013, the investigator visited Wakefield's security department and spoke to the prison's family liaison officer.

10. NHS North Yorkshire and Humberside appointed a clinical reviewer to review the man's clinical care in prison.

11. HM Coroner for West Yorkshire Eastern District was informed of the investigation and a copy of the report has been sent to him.

12. One of the Ombudsman's family liaison officers contacted the man's brother to explain the purpose of the investigation. The man's brother did not have any specific issues for the investigation to consider but said he was surprised that he had not heard from anyone at the prison and did not know the circumstances of his brother's death. The Ombudsman's family liaison officer contacted Wakefield's family liaison officer and asked her to speak to the man's brother. The man's brother reviewed this report in draft, and was content that it was accurate.

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

HMP WAKEFIELD

14. HMP Wakefield is one of eight high security prisons in England and Wales. It holds 750 Category A, B and high security remand prisoners. There are four main residential wings, a healthcare centre, segregation unit and close supervision centre. The man was a category A prisoner and lived on B wing. All cells are single occupancy. Primary care services are provided by Spectrum CIC (Community Interest Company) during normal working hours. The inpatient unit is staffed by nurses employed by Humber NHS Foundation Trust (intermediate care), who also provide overnight and weekend cover for patients with physical health problems at Wakefield.

HM Inspectorate of Prisons

15. The Inspectorate carried out an unannounced full follow-up inspection of Wakefield in May 2012. Inspectors found that health provision had significantly improved since the last inspection. The range of primary care services was considered to be of a good standard and appropriate for the population, including older prisoners.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report, the IMB noted that healthcare provided a comprehensive service that met the needs of the population.

Previous deaths at Wakefield

17. The man's death was one of six from natural causes at Wakefield this year. Following the death of a prisoner five days before the man's, the prison asked the police to break the news of the prisoner's death to his family, which caused a significant delay. We are critical of family liaison arrangements in this case, and make the same recommendation made in that report.

ISSUES

The diagnosis of the man's terminal illness

18. On 11 December 2012, the man told the doctor that he had a persistent cough. The doctor referred him to a visiting respiratory specialist who holds monthly clinics in Wakefield's healthcare centre. On 9 January 2013, The respiratory specialist examined the man and requested a chest X-ray and a spirometry test. (A spirometry test measures lung function and breathing.) The clinical reviewer notes that as cancer was not suspected at this time, an urgent referral would not have been expected.

19. Another doctor noted in the man's medical record on 28 February, that X-rays showed chronic obstructive pulmonary disease (COPD - a condition that causes breathing difficulties), and a nine millimetre swelling on the man's right lung. The doctor ordered a routine CT scan.

20. The respiratory specialist examined the man on 6 March and felt a lump in his lower back area. He told the man that he would change the request for the CT scan to urgent, because he was now concerned that he might have cancer. On 27 March, the man was due to have the CT scan at Pinderfields Hospital but he was not taken to this appointment. The doctor noted in the man's medical record that the scan had been urgent and should not have been cancelled for prison related reasons.

21. The investigator checked the security department's daily escort diary which contained no entry for the man on 27 March. The prison has been unable to explain why this appointment did not take place but the doctor's entry in the medical record indicates it was the prison's decision. A further scan was then arranged for 11 April, the results of which indicated that the man had a cancer tumour on his lung and that the cancer had spread to his bones. The illness was not curable. On 3 May, another CT scan showed that cancer had spread to the man's liver.

22. We agree with the clinical reviewer that the man's symptoms were responded to promptly by doctors at the prison. However, the failure to take him for the 27 March CT scan led to a delay of two weeks in his diagnosis. As the scan on 11 April showed that the man's cancer was already terminal at that stage and had spread to other parts of his body, the delay was unlikely to have changed the outcome in this case but was likely to have caused the man added anxiety. In other cases such a delay in diagnosis could be crucial. We make the following recommendation:

    The Governor should ensure that prisoners are taken to all urgent hospital appointments as arranged and that changes are not made to hospital appointments unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.

Informing the man about his condition

23. On 6 March, the respiratory specialist explained to the man that he was concerned he might have cancer. The doctor noted in the man's medical record on 8 March that he was aware of the possibility of cancer. He was offered emotional support for the possible diagnosis.

24. On 24 April, the respiratory specialist told the man that the CT scan had shown a cancerous tumour on his lung, and the cancer had spread to his bones and was not curable. The doctor discussed tests and said that possible treatments dependent on the outcome of further scans, X-rays and biopsies.

25. It is evident from the man's medical record that healthcare staff worked as a team to ensure the man was kept fully informed and supported during the diagnostic process. However, it soon became apparent that his illness was at an advanced stage. Treatments to address the man's progressive cancer were deemed to be inappropriate and not beneficial given his poor prognosis.

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26. We agree with the clinical reviewer that the man was adequately informed and understood his diagnosis and his limited treatment options.

The man's medical treatment

27. The man saw the respiratory specialist regularly in his respiratory clinic after his diagnosis but he had no hospital appointments to treat his cancer. As noted, the man's cancer was at an advanced stage and could not be cured. In early May, the man refused surgery to relieve a blockage in his bile and pancreatic ducts when he became jaundiced. Palliative chemotherapy was not started because the man's cancer was too advanced.

28. The clinical reviewer notes that it was evident from the man's medical record and care plans that he received appropriate treatments.

Palliative Care

29. On 24 April, the respiratory specialist explained to the man about a document known as a Do Not Resuscitate (DNR - a legal document respecting the wishes of the patient not to be resuscitated should they have a cardiac or respiratory arrest. The man signed a DNR form two days later.

30. On 25 April, a doctor and healthcare staff at Wakefield held a multi disciplinary meeting to discuss the man's care, and a gold standard palliative care plan was started. On 5 May, a full nursing palliative care plan was opened with assistance from a MacMillan nurse, who liaised with healthcare staff and visited the man regularly until his death. Another doctor arranged for the man's cell door to be left open from 21 June and an officer sat at his bedside.

31. At 3.15pm on 24 June, the man was placed on a care pathway for the dying. At around 7.50pm, a nurse could not find the man's pulse and he had stopped breathing and believed he had died. She called a paramedic who, at 8.10pm confirmed that the man had died.

32. The clinical reviewer concludes that the man received appropriate palliative care.

The man's pain relief and medication

33. On 9 January the man was prescribed ibuprofen for pain relief, which appeared to control his pain until co-codamol was prescribed on 21 March. The man's pain relief medication was regularly reviewed and he was told that there was stronger pain relief, should he need it.

34. When he was admitted to the healthcare centre on 29 April, the man's pain relief was reviewed daily. He was prescribed tramadol and morphine near the end of his illness and encouraged to take his pain relief.

35. The man was prescribed fortijuice, a nutritional drink supplement, when he could not eat food. Towards the end of his life, the man was prescribed haloperidol, used to calm restlessness.

36. The clinical reviewer notes that the man's was frequently reminded to let staff know if he needed more pain relief. We are satisfied that he received appropriate pain relief and medication.

The man's location

37. After his terminal diagnosis, the man was asked whether he wanted to stay on his wing or move to the healthcare centre. He chose to move to the healthcare centre on 29 April and was able to visit his wing to see his friends. He received daily visits from the prison chaplain.

38. On 8 May, the prison's disability officer visited the man to see if he needed any assistance or appliances to improve his day to day living. The man declined the officer's offer, but was given a pressure-relieving mattress and compression socks to prevent his legs from swelling.

39. The clinical reviewer notes that it was clear from the man's medical record that he settled into a routine in the healthcare centre, and was independent for much of his time there. He was could look after himself until a few days before his death. We agree with the clinical reviewer that the healthcare centre had the facilities to care for a terminally ill patient and that he was properly consulted about where in the prison he wanted to be throughout his illness.

Restraints, security and bed watch

40. The respiratory specialist wrote a letter to a GP at Wakefield, on 30 April, saying that the man had had a "bad experience of a scan for security reasons". The doctor wrote that the man was not sure if he wanted further treatment outside the prison as a result. We assume that this related to the scan which took place on 11 April.

41. The prison could not find the man's personal escort records (PERs) or escort risk assessments. The security department told the investigator that all category A prisoners are double cuffed when away from the prison and an escort chain is used for treatments. A security officer said it was most likely that this applied to the man. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. An escort chain is a two metre long chain with a cuff at each end attached to the prisoner and an officer.)

42. 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. 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 judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing 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.

43. It is unsatisfactory that the prison had been unable to provide the man's escort risk assessments and without them we cannot make an assessment of whether the arrangements were appropriate and followed the High Court guidance. However, it is evident from the what the security department said that they tend to adopt a blanket approach to the security arrangements for category A prisoners and did not appear be aware of the implications of the 2007 High Court judgment or the subsequent Prison Service guidance which was issued by the Head of Security Group in April 2008. We make the following recommendation:

The Governor should ensure that all officers working in Wakefield's security department are fully briefed about the implications of the 2007 High Court judgment and take it into account when making risk assessments for prisoners attending hospital for treatment.

Compassionate release or Release on Temporary Licence

44. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminately sentenced prisoners are set out in PSO 4700. The criteria include 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 early release on compassionate grounds must be submitted to the Public Protection Case work Section (PPCS) within the National Offender Service (NOMS). There is no evidence that the prison started an application for the man to be considered for early release on compassionate grounds after his terminal diagnosis in April.

45. In May, the man said to a nurse that he might ask his solicitor to apply for release on compassionate grounds, but he thought it unlikely that he would be successful. We do not know whether The man spoke to his solicitor about this and it is possible that he took advice and decided not to proceed. The man told the respiratory specialist that he wanted to die in prison, and was content to be in the healthcare centre. It seems unlikely that the man would have fulfilled all the criteria for compassionate release but we consider it is important that the possibility of compassionate release is discussed with all terminally ill prisoners as part of their end of life care planning. We make the following recommendation:

The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

Liaison with the man's family

46. When the man was first diagnosed he told the respiratory specialist that he did not want to contact his family. He said he had two brothers, but he had not been in touch with them for 30 years.

47. The prison family liaison officer, met the man the day he was diagnosed and offered her support, but did not contact his family, in line with his wishes. She visited the man frequently throughout his terminal illness and spoke to him about contacting his family several times more, but he still did not want to contact them. He then gave the family liaison officer his brothers' contact details for her to contact them on his behalf, but the details were out of date. When she explained this to the man, he said he did not want contact with his

brothers and she should not try again. There is no evidence that the family liaison officer tried to obtain the man's brothers' correct contact details, which would be needed when he died.

48. On 17 June, the nurse asked the man again if he wanted contact with his family, but again he preferred not to contact them.

49. Around 9.00pm on 24 June, the family liaison officer was contacted at home and told that the man had died. She spoke to the duty governor who advised her to contact the local police and ask them to trace the man's brother and break the news of his death on the prison's behalf. The police contacted the family liaison officer the next day to confirm that they had visited one of the man's brother's and informed him of his brother's death. They said that the man's brother had said that he was not interested and he would not be contacting the prison. The family liaison officer did not contact the man's brother herself.

50. On 27 June, the police contacted Wakefield's control room for any more information on the man's other brother. The family liaison officer gave them his name and old address and asked them to tell her if he wanted to be involved in the funeral arrangements. The police did not contact the family liaison officer again and she did not speak to them.

51. The family liaison officer arranged the man's funeral with the prison chaplain, who officiated at a service on 15 July.

52. On 23 July, the Ombudsman's family liaison officers, spoke to the man's brother, who the police had visited on 24 June. He told the Ombudsman's family liaison officer that the police had told him that the prison would contact him. He said he had not heard anything from Wakefield and wanted to know more about the circumstances of the man's death. The Ombudsman's family liaison officer informed the prison's family liaison officer who then contacted the man's brother. The family liaison officer explained that the man had died of terminal cancer and did not want his family to know about his illness while he was alive. The man's brother told the family liaison officer that his other brother was dead.

53. PSI 64/2011 Safer Custody, chapter 13, states:

> "*Wherever possible, the FLO 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.
>
> "*Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.*

"*If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable.*"

The family liaison officer should have got correct contact details for the man's family to inform them without delay in the event of his death. The prison should have visited the man's brother themselves, or if the distance was too great, they should have asked a representative from a nearby prison to break the news on their behalf, in line with the PSI. As the police notified the man's family, the prison should have offered a follow up visit.

54. The failure to follow the requirements of PSI 64/2011 meant that the man's brother was not told of his death by a prison representative and was not contacted by the prison at all until this office intervened. There appears to have been some miscommunication between the police and the prison but this emphasises the need for Prison Service representatives to speak to family members themselves in line with Prison Service instructions. We make the following recommendation.

The Governor should ensure that in the event of a death, prisoners' families are informed quickly by a member of Prison Service staff where possible and that there is a follow up visit by Wakefield staff when they have not been able to deliver the news themselves.

Recommendations

1. The Governor should ensure that prisoners are taken to all urgent hospital appointments as arranged and that changes to any hospital appointments are not made unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.

2. The Governor should ensure that all officers working in Wakefield's security department are fully briefed about the implications of the 2007 High Court judgment and take it into account when making risk assessments for prisoners attending hospital for treatment.

3. The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

4. The Governor should ensure that in the event of a death, prisoners' families are informed quickly by a member of Prison Service staff where possible and that there is a follow up visit by Wakefield staff when they have not been able to deliver the news themselves.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that prisoners are taken to all urgent hospital appointments as arranged and that changes to any hospital appointments are not made unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.	Accepted	A reminder has been issued to all medical staff to ensure that all reasons for cancellation of Hospital appointments are recorded on SystmOne and that urgent appointments are not cancelled. Non urgent appointments are at times rescheduled to take into account operational and staffing resource issues but only where medical staff advise that there will be no detriment to a prisoner's health. The decision to cancel an appointment will made by a Clinical Manager with due regard to the urgency of the appointment.	Completed Head of Drug Strategy and Healthcare Provision.	
2	The Governor should ensure that all officers working in Wakefield's security department are fully briefed about the implications of the 2007 High Court judgment and	Accepted	The Head of Security and Operations has briefed and e-mailed all staff of all grades within the Security and Intelligence Department to ensure that: - all risk assessments are individually assessed based on current intelligence and	Completed Head of Security and Operations	

	take it into account when making risk assessments for prisoners attending hospital for treatment. .		medical presentation. - Relevant input from clinical staff is provided to make an accurate assessment of restraint arrangements.		
3	The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.	Accepted	Although applications for compassionate release cannot be made on a prisoner's behalf , on diagnosis of a terminal illness, prisoners at HMP Wakefield will be advised of the possibility of compassionate release regardless of whether they meet the criteria Where the criteria are not met this will be recorded with the associated reasoning and subject to ongoing review in response to changes in circumstances	Completed Head of Corruption Prevention and Counter Terrorism	
4	The Governor should ensure that in the event of a death, prisoners' families are informed quickly by a member of Prison Service staff where possible and that there is a follow up visit by Wakefield staff when they have not been able to deliver the news themselves.	Accepted	Following a prisoner's death, regardless of a prisoner's previous position on contact, appropriate efforts will be made to locate and contact their family at the earliest opportunity. Such contact will be made by HMPS staff, barring exceptional circumstances and the basis for any such decision will be recorded. Where the initial contact is made by non HMPS staff, a follow up visit will be made as appropriate in accordance with the family's wishes.	Completed Head of Corruption Prevention and Counter Terrorism	