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 Elmley in March 2014

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 widespread cancer in March 2014 at HMP Elmley. He was 47 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care that the man received at Elmley. The prison cooperated fully with the investigation.

In November 2013, the man was remanded to HMP Elmley and subsequently sentenced to 20 months in prison. Healthcare staff saw the man frequently for drug detoxification treatment and for an ulcer on his leg.

In February 2014, the man complained of a pain in his neck. The GP considered this was a trapped nerve and noted he would request an X-ray. The pain continued and the man attended two more appointments and doctors prescribed pain relief and sleeping tablets. On 7 March, a prison GP found enlarged lymph nodes in the man's neck and abdomen and requested blood tests to rule out cancer. The blood test was carried out five days later. The results of the blood test were concerning and the man was admitted to Medway Maritime Hospital on 13 March, where he had emergency bowel surgery. On 24 March, the results of a CT scan showed that he had widespread advanced cancer. The man died in hospital the same day.

The clinical reviewer found that most of the man's care in prison was satisfactory, but was concerned that an X-ray requested in February had not been carried out and that blood tests requested on 7 March were not carried out urgently. This was unlikely to have affected the outcome for the man, as his cancer was particularly aggressive. However, it is important that such tests are carried out promptly as the earlier a diagnosis is made, the more chance there is of effective treatment.

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 2014**

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SUMMARY

1. On 21 November 2013, the man was remanded to HMP Elmley charged with robbery. At his reception health screen, the man said he had taken drugs in the community and he was referred to the substance misuse team. He also said he had hepatitis C and had received treatment in the past. On 9 December, he was sentenced to 20 months in prison.

2. Healthcare staff saw the man frequently to administer medication as part of his drug detoxification treatment and to treat ulcers on his legs

3. On 3 February 2014, a nurse prescribed pain relief for muscle strain when the man reported a pain in his neck. On 17 February, the man's pain was no better and a nurse made an appointment for him to see the GP.

4. A GP examined the man on 19 February and thought he might have a trapped nerved. The GP noted that he would request an X-ray. On 24 February, a nurse noted that they would need to send the man to hospital for the X-ray if there was no radiographer available in the prison.

5. On 3 March, a prison GP saw the man. The GP noted that the physiotherapist was unable to work with the man as his neck was in spasm. The GP prescribed pain relief and noted that the man was still waiting for an X-ray.

6. Another prison GP examined the man on 7 March and found a chain of enlarged lymph nodes in his abdomen and neck. The GP referred the man for blood tests to rule out cancer. On 12 March, the man had the blood tests and an X-ray at hospital was arranged. The blood tests showed a high count of white blood cells (which can indicate infection and inflammation). On 13 March, the GP spoke to a consultant at Medway Maritime Hospital about the man's blood test results and he was admitted to hospital the same day.

7. The man had bowel surgery and remained in the hospital's intensive care unit. On 24 March, the hospital informed the prison that a CT scan had revealed the man had a widespread cancer with unknown origin and that his prognosis was uncertain. The man died the same day at 9.05pm. His family were with him at the time.

8. The clinical reviewer found that the majority of the man's care in prison was satisfactory. However, had the X-ray and blood tests been treated as urgent and the results available on 7 March, the man would have probably been admitted to hospital as an emergency and diagnosed earlier. Given the seriousness of his cancer this is unlikely to have altered the outcome in the man's case but it is important that such tests are carried out promptly. We make one recommendation.

THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records and interviewed two members of staff by telephone on 12 and 15 May. She wrote to the Governor about the preliminary findings of the investigation.

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

12. We informed HM Coroner for Mid Kent and Medway of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's mother, his nominated next of kin, to explain the investigation. The man's sister e-mailed the family liaison officer and asked when the man had first informed prison staff that he was sick and what medical treatment he had received in prison.

14. The man's family received a copy of the draft report. The man's family remain concerned that his loss of weight was not identified on 3 February, and he did not have access to his medication when in segregation. The man's family also raised a question about missed medical appointments, which has been clarified in separate correspondence. The prison has submitted an action plan detailing what they have done to address the issue we raised and this is included at the end of the report.

HMP ELMLEY

15. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells

16. At the time of the man's death, NHS England, Kent and Medway commissioned Integrated Care 24 Ltd (IC24) to provide primary healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of prisons

17. The most recent inspection of HMP Elmley was in March 2012. The Inspectorate found that, overall, access to and quality of healthcare was generally good. Inspectors noted that GP clinics took place regularly and a high rate of non-attendance had recently reduced significantly. There was a good range of nurse and specialist led clinics and attendance at outside hospital appointments was well managed.

Independent Monitoring Board

18. Each prison in England and Wales 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 recently published report for the year to October 2013, the IMB noted that since the takeover of primary healthcare by South East Health (now known as IC 24) in February 2013, 45 new staff had been employed. There were plans to open clinical consulting rooms on all six houseblocks which it was hoped would relieve waiting times in outpatients and reduce the rate of non-attendance at appointments. Overall, the IMB noted that healthcare staff did an excellent job, and were helpful and hardworking.

Previous deaths at HMP Elmley

19. The man was the third prisoner to die from natural causes at Elmley since the start of 2012. There have been two further deaths since. We have raised the issue of follow up of blood test results before.

KEY EVENTS

20. On 21 November 2013 the man was remanded to HMP Elmley for robbery and breach of the requirements of a suspended sentence. At his initial health screen, he reported a history of drug misuse. He was referred to the substance misuse team and was prescribed methadone daily. He said that he had been diagnosed with hepatitis C and had received treatment in the past. The man was a cigarette smoker and was offered smoking cessation advice, which he declined. Healthcare staff saw the man frequently for his drug withdrawal treatment and ongoing hepatitis C therapy.

21. On 9 December 2013, the man was sentenced to 20 months in prison and returned to HMP Elmley. From 9 December 2013 to January 2014, healthcare staff saw the man a number of times to treat ulcers on his legs.

22. On 3 February 2014, the nurse examined the man in healthcare after he complained of pain in his neck. She prescribed ibuprofen gel for muscle strain. On 17 February, the man told the nurse that his neck pain had continued and the nurse arranged an appointment with a prison GP.

23. The GP examined the man on 19 February. He noted a possible trapped nerve and that he would refer the man for an X-ray of his cervical spine.

24. On 22 February, when the man went to collect his methadone, the nurse recorded that he was crying and in obvious pain. He told her that he could not sleep or eat and was finding it increasingly difficult to move. The next day, a nurse practitioner prescribed sleeping tablets for two nights.

25. On 24 February and 3 March, entries in the man's medical record note that he had still not had an X-ray. On 24 February, a nurse noted that the X-ray needed to be chased up and if a radiographer was not available in the prison then he would need to go to hospital for the X-ray. On 3 March, a prison GP noted that the physiotherapist had seen the man but was unable to help him as his neck was in so much spasm. The doctor advised him to rest and apply hot compresses and prescribed pain relief.

26. Another prison GP examined the man on 7 March. The man told the GP that he had noticed lumps on the right side of his abdomen and neck. The GP noted a chain of enlarged lymph nodes along the side of the man's abdomen, left groin and the left side and lower right side of his neck. He referred the man for blood tests to rule out cancer. The GP recorded that the man had still not had the X-ray. He prescribed an anti-inflammatory and a soft collar. He arranged an appointment for a week later but noted that he should be seen earlier if his condition deteriorated.

27. The man had blood tests on 12 March and the results showed that he had a high neutrophil count (white blood cells). A high count can indicate infection and inflammation. The GP noted that the man had still not had his X-ray and arranged for this to be done externally. On 13 March, the GP spoke to a

medical consultant at Medway Maritime Hospital about the results, who advised that the man should go to hospital immediately.

28. An escort risk assessment was completed and recorded that the man was a low risk to others and of escape. Healthcare staff did not object to the use of restraints and noted the man was in pain but medicated. He was restrained by a single handcuff on the journey and by an escort chain at the hospital. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

29. The man was admitted to hospital and had an emergency operation on his bowel. His restraints were removed for the operation and were never used again. On 15 March, the man was reported to be critically ill and under sedation in the hospital's intensive care unit.

30. The nurse rang the hospital on 17 March and recorded that hospital staff were reluctant to give any information about the man over the telephone. The nurse attended the hospital on 20 March to receive an update in person and recorded that the man remained in an induced coma and his condition was stable.

31. The escort staff remained with him for support. It was agreed that the man's family could visit him during normal hospital visiting hours and they visited him frequently from then on.

32. On 24 March, hospital staff informed the prison that a CT scan had revealed the man had widespread cancer and his prognosis was uncertain. The prison started the compassionate release process immediately.

33. At 9.05pm the same day, the man died. His family were with him at the time.

Liaison with the man's family

34. It is unclear from the records when the man's family were first informed that he had been admitted to hospital, but escort records indicate that the man's family visited him on 16 March and several times afterwards. After the man died, the prison appointed the Reverend as the family liaison officer.

35. The Reverend spoke to the man's mother and brother the day after he died. The Reverend told the investigator that he offered to visit his family but they declined. In line with national policy, the prison made a contribution towards the funeral. The prison held a memorial service on 31 March. The man's funeral took place on Tuesday 22 April. Two members of prison staff attended.

Support for staff and prisoners

36. A debrief for staff was held on 24 March. A Governor's notice informed staff and prisoners of the man's death and offered support if required.

Post-mortem

37. A post-mortem examination concluded that the man died from carcinomatosis (multiple cancers) that possibly originated in the upper intestines.

ISSUES

Clinical care

38. The clinical reviewer concluded that the majority of the man's care in prison was satisfactory. However, he says an opportunity to diagnose the man earlier was missed because tests were not carried out quickly enough. Blood tests requested on 7 March were not completed until 12 March and an X-ray requested on 19 February was never done. For this reason, the clinical reviewer considers the man's standard of care was not equivalent to that which he would have received in the community. However, as the cancer was very aggressive, the clinical reviewer states that it is unlikely that an earlier diagnosis would have changed the outcome.

Medical investigations

39. On 19 February, the GP noted that he would refer the man for an X-ray because of the pain in his neck. It appears that this was expected to be carried out in the prison, but this was not done. It was not until 12 March that a GP arranged for this to be done at hospital. The man was admitted to hospital the next day.

40. On 7 March, the GP reviewed the man and was concerned about a number of lumps in his abdomen and neck. He requested blood tests to rule out cancer. The clinical reviewer said that, although the GP could have made an urgent referral to a specialist for suspected cancer, it was not clear which speciality he would have referred the man to, without the results of these investigations. However, he considers that the blood tests should have been taken the same day or the next day, but they were not done until 12 March. The clinical reviewer states that if X-ray and blood test results had been available to the GP on 7 March, it is very likely that the man would have been sent to hospital as an emergency that day. He noted that the prison GP did not seem to be aware how long tests might take or specify how soon they needed them to be done.

41. There does not appear to be an efficient process to ensure urgent investigations and blood tests are carried out without delay. The clinical reviewer points out that, although it is unlikely to have affected the outcome for the man, the opportunity for an earlier diagnosis was missed. We make the following recommendation:

    The Head of Healthcare should ensure that there is an efficient process for urgent tests to be prioritised and carried out without delay.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there is an efficient process for urgent tests to be prioritised and carried out without delay.

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ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that there is an efficient process for urgent tests to be prioritised and carried out without delay.	Accepted	All GPs and clinical staff have been provided with a timetable of planned clinical services at HMP Elmley and the days that they operate. If a clinician feels that investigations cannot wait until the next planned clinic, arrangements will be made for these to be carried out at an external NHS facility.	Completed Head of Healthcare