A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in November 2014, while a prisoner at HMP Wymott

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 lung cancer in November 2014, while a prisoner at HMP Wymott. He was 61 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Wymott was undertaken. The prison cooperated fully with the investigation.

The man had been in prison since May 2013 and at Wymott since January 2014. In July 2014, he had a chest infection and complained of feeling sick. At the end of August, he was admitted to hospital with a suspected stroke. Scans and X-rays (including one of his chest) did not reveal any problems. A further chest infection and X-ray in October, led to a diagnosis of lung disease and anaemia.

On 31 October, the man developed severe chest pains and was admitted to hospital. Tests revealed he had lung cancer which had spread to his spine. He remained in hospital and, on 17 November, hospital staff told him that his death could be imminent. The prison did not start an application for his early release until 25 November. He died in hospital a few days later, before the application could proceed.

The investigation found that the man received a generally good standard of care, equivalent to that he could have expected to receive in the community. I am, however, concerned that there was a delay in considering early release on compassionate grounds.

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 **June 2015**

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SUMMARY

1. On 20 May 2013, the man was convicted of sexual offences and subsequently sentenced to two years and three months in prison. He had a history of coronary heart disease and psoriasis. At first, he was held at HMP Manchester, but was moved to Wymott in January 2014.

2. The man had a chest infection at the beginning of July 2014. Healthcare staff offered him help to stop smoking and he went to a smoking cessation clinic intermittently. In August, he was admitted to hospital with a suspected stroke, but scans, X-rays of his head and chest and blood tests, were all normal.

3. On 21 October, the man had another chest infection and was admitted to hospital for two days. An X-ray revealed abnormalities consistent with a chest infection and doctors diagnosed chronic lung disease. The hospital discharged him on 23 October. During the evening of 31 October, he experienced severe chest pains. Healthcare staff sent him as an emergency to hospital. Two officers accompanied him, using an escort chain.

4. On 3 November, the hospital suspected that the man had had a stroke and their emergency team resuscitated him. The escort officers removed the escort chain, but reapplied it an hour and a half later. That afternoon, as his condition and mobility had deteriorated, a prison manager agreed the escort chain could be removed and it was not used again.

5. The man remained in hospital and on 13 November, hospital staff told healthcare staff at the prison that he had lung cancer, which had spread to his spine. Scan results were still needed for a clear prognosis. The same day, a prison nurse informed staff in the prison's offender management unit (who were responsible for coordinating applications for early release on compassionate grounds) that his condition was terminal, with a life expectancy of around two months.

6. On 17 November, hospital staff told the man that his death could be imminent. The prison appointed a family liaison officer who visited him in hospital and then went to see his brother to let him know. The prison began an application for early compassionate release but did not give it sufficient priority and he died before this could be progressed.

7. We agree with the clinical reviewer that, overall, the man received a standard of care equivalent to that he could have expected in the community, but we are concerned that there was a delay in processing the application for compassionate early release.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records.

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

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

12. One of the Ombudsman's family liaison officers tried to contact the man's brother by telephone but got no response to a message. She subsequently wrote to him to explain the investigation and asked if there was anything he wanted the investigation to consider. He did not reply. He received a copy of the draft report. He did not make any comments.

13. The prison also considered our draft report and raised a factual inaccuracy which has been amended. They submitted an action plan addressing our recommendation which is at the end of this report.

14. The investigation has assessed the main issues involved in the man's care, including his diagnosis, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

HMP Wymott

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

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wymott was in July 2014. Inspectors found the quality of healthcare was reasonably good, but undermined by long delays and poor access to GPs and the dentist. The range of clinics provided reflected the needs of the prison population, including for chronic diseases.

Independent Monitoring Board (IMB)

17. In its most recently published report for the year to May 2014, the IMB noted that waiting times for GP appointments was an issue, but the triage system operated by the nurse-practitioner had ensured that urgent cases were seen promptly. They commented that managers and staff have worked hard to maintain Wymott as a prison that holds prisoners with safety, decency, respect and security.

Previous deaths at HMP Wymott

18. The man's death was the fifth of eight deaths from natural causes at Wymott since 2013. (In addition, five prisoners from Wymott prisoners died after transferring to the inpatient facility at Preston.) We have made previous recommendations to Wymott about prioritising early release applications for terminally ill patients.

ISSUES

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

19. The man had been in prison since 27 June 2013 and began his sentence at HMP Manchester. He had a history of coronary heart disease and psoriasis. On 11 July 2013, a nurse offered him help to give up smoking, but he did not want to stop. On 20 October 2013, he reported severe chest pain and was admitted to hospital. The hospital diagnosed costochondritis (a painful but not serious condition causing pain in the chest wall). He did not report any further chest symptoms for nine months.

20. On 27 January 2014, the man transferred to Wymott. On 2 July, a prison GP prescribed him an antibiotic to treat a chest infection. The next day, he told a nurse that he felt sick. The GP considered the nausea to be a side effect of the antibiotic, so changed his prescription and added an anti-sickness tablet.

21. On 17 July, the man attended a smoking cessation clinic and was prescribed nicotine patches and inhalers. After this, he missed some sessions and staff suspected he was still smoking, as they could smell smoke in his cell.

22. On 28 August, the man complained of chest pain, a heavy right arm and a headache on the left side of his head. He was admitted to hospital and had a CT scan of his head, an X-ray of his chest and blood tests. All the results were normal and the hospital discharged him on 31 August. The hospital recommended a scan to assess if the arteries to his brain had narrowed. There is no record whether this was done.

23. In October, doctors treated the man for another chest infection. On 21 October, he was admitted to hospital and a chest X-ray revealed abnormalities indicative of a chest infection. The hospital discharged him on 23 October, with a diagnosis of chronic obstructive pulmonary disease (COPD). His blood results showed he was slightly anaemic.

24. On 31 October, a GP reviewed the man, who reported being breathless. The doctor noted an inflammation around the wall of his right lung and prescribed antibiotics for a chest infection. He took a blood sample, which later indicated a likelihood that he had a disease. That evening, he reported severe chest pain and healthcare staff sent him as an emergency to hospital.

25. There is little information about the man's stay in hospital but on 3 November, the emergency team resuscitated him, after he had a suspected stroke. Healthcare staff at the prison found it difficult to get information from the hospital about his condition.

26. On 13 November, a prison nurse spoke to a doctor at the hospital, who told her that the man had lung cancer, which had spread to his spine. The doctor said that his prognosis was very poor, but they were waiting for MRI scan results, which they would discuss at a multidisciplinary team meeting a few days later. The doctor thought his life expectancy was around two months at

the time. On 17 November, hospital staff told the man that he might die very soon.

27. We are satisfied that prison healthcare staff appropriately reviewed and referred the man to hospital promptly when his clinical condition indicated this was necessary. Hospital staff informed him of his diagnosis. We agree with the clinical reviewer that his care was equivalent to that which he could have expected to receive in the community.

The man's medical treatment

28. The man's cancer was diagnosed while he was in hospital and he did not return to the prison. He had scans to determine the extent of his disease and hospital staff kept him informed him of his prognosis. His treatment in hospital is outside our remit. The hospital gave prison healthcare staff occasional updates about his condition, which indicated that specialist nurses were involved in his end of life care.

The man's location

29. The man was in hospital for the duration of his illness, after his diagnosis, and remained there until he died on 28 November. He had no need of any special accommodation before he went to hospital and we are satisfied that he was appropriately located.

Restraints, security and escorts

30. 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 the 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 judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

31. Before the man went into hospital on 31 October. A custodial manager completed a security risk assessment. She highlighted that he was subject to safeguarding children measures, but the form had little other information. A nurse, who completed the medical section of the risk assessment, said that he was not incapacitated, his condition was not life threatening, he was able to escape unaided and there was no objection to the use of restraints. A custodial manager decided that two officers should escort him and use an escort chain to restrain him. (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.)

32. On 3 November, at approximately 9.30am, the hospital's emergency team resuscitated them an after a suspected stroke. The escort officers removed the restraints and informed a custodial manager. With the custodial manager's approval, they reapplied the restraints at 11.00am. At 3.00pm that afternoon, the deputy governor reviewed his risk and noted that his lung condition had deteriorated since his initial admission and this had affected his mobility. She agreed that the restraints should be removed and they were not used again.

33. We consider the need for the man to be restrained should have been fully considered and reviewed again promptly after his suspected stroke on 3 November. However, we recognise that this was done a few hours later and we are pleased to note that he was not restrained for the last three and a half weeks of his life.

Liaison with the man's family

34. On 17 November, the prison appointed an officer as the man's family liaison officer after he was told that he had not long left to live. The officer visited him in hospital and spoke to him about his last wishes. The man checked his brother's contact details with him, as he had named him as his next of kin. In the event, they turned out to be incorrect. The officer obtained the correct details from the Probation Service and went to see him in person to tell him that the man was seriously ill. The man's brother visited him in hospital and the officer kept him informed about his brother's condition.

35. When the man died, the officer phoned the man's brother to tell him the news, as they had previously agreed. He stayed in contact and helped arrange the funeral. The prison contributed to the funeral costs, in line with national guidance.

36. The funeral was held on 18 December. The officer, a prison manager and the prison chaplain attended.

Compassionate release

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

38. On 13 November, a nurse learnt from the man's hospital doctor that his life expectancy was around two months and spoke to staff in the prison's offender management unit, about the possibility of compassionate release. The staff advised that they would need written confirmation of the situation. On 17 November, hospital staff told his that his death could be imminent. A prison GP did not complete the medical assessment section of an early release form until 25 November. He supported the application and indicated that the man's prognosis was poor.

39. Also on 25 November, a probation officer at the prison completed the public protection section of the application and submitted it to her manager. She did not support his release as there was no clear medical treatment pathway, without which she unable to formulate a release plan. The probation officer noted that the man had not addressed his offending behaviour, rather than commenting on whether his condition meant that the risk of re-offending was past, which is the appropriate test for early release on medical grounds.

40. Neither the doctor nor the probation officer obtained up to date reports from the hospital at the time they completed their contributions and it was not clear who was responsible for taking the application forward. The application form was not completed on 25 November and he died a few days later. We are concerned that compassionate release process was poorly managed and lacked coordination. There is no evidence that anyone ever discussed with him whether he wanted compassionate release and it is not clear that he met the criteria, but if he did, the application was not given sufficient priority. We make the following recommendation:

The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with without delay. Staff completing applications should make a distinction between the risks posed by prisoners when fit and their risk when suffering from a terminal condition.

RECOMMENDATION

The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with without delay. Staff completing applications should make a distinction between the risks posed by prisoners when fit and their risk when suffering from a terminal condition.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds in each case and that these are dealt with without delay. Staff completing applications should make a distinction between the risks posed by prisoners when fit and their risk when suffering from a terminal condition.	Accepted	A flow chart has been produced which outlines the process for considering release on compassionate licence, at the earliest opportunity, by the Head of OMU. In the absence of the Head of OMU the Duty Governor or other Operational Manager will undertake this task, the paperwork and guidance is contained within the Control Room.	Completed (December 2014)