Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Astbury a prisoner at HMP Stafford on 6 February 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

Mr John Astbury died on 6 February 2016 of lung cancer, while a prisoner at HMP Stafford. He was 70 years old. I offer my condolences to Mr Astbury's family and friends.

Mr Astbury was appropriately referred by a prison GP for an urgent X-ray when his symptoms suggested it, and healthcare staff referred him for an urgent specialist appointment, when they received the results. After his diagnosis, Mr Astbury was well looked after at Stafford. Prison healthcare staff fully supported him and I am satisfied that his care was equivalent to that he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

Contents

Summary

Events

1. On 7 June 2011, Mr John Astbury was sentenced to 15 years in prison. He had been at HMP Stafford since 16 September 2015. On 29 September, Mr Astbury reported a persistent cough. A prison GP referred him for a chest X-ray, which he had the next day. A radiologist noted that the results indicated a malignancy and recommended an urgent specialist referral for suspected cancer. The hospital did not send the radiologist's report to the prison for nearly two weeks, but, after it was received on 13 October, healthcare staff made an urgent referral. On 16 October, a prison GP discussed the X-ray results with Mr Astbury and informed him that it was likely he had cancer.

2. On 9 November, investigations confirmed that Mr Astbury had lung cancer, which had spread to his liver. On 18 November, an oncologist told him that the cancer was incurable and his care would be palliative. Mr Astbury did not want to discuss his diagnosis with healthcare staff but agreed that the prison should inform his sister. In late November, Mr Astbury began palliative chemotherapy.

3. Mr Astbury preferred to care for himself, but, from 25 December, a trained prisoner carer helped him with daily living tasks. In January, his condition deteriorated and he was too unwell to continue chemotherapy. He decided that he did not want to be resuscitated if his heart or breathing stopped.

4. On 27 January, Mr Astbury was treated briefly in hospital with intravenous fluids to rehydrate him. His condition continued to decline and, on 1 February, he was moved to a hospice for end of life care. He died at the hospice on 6 February.

Findings

5. A GP appropriately referred Mr Astbury for an X-ray as soon as he reported a persistent cough. There was a delay of 12 days before the hospital informed the prison of the results of the X-ray but the clinical reviewer was satisfied that this made no difference to the outcome, as the cancer was already very advanced. Mr Astbury received treatment after his first referral, within the NHS target. We are satisfied that prison healthcare staff referred Mr Astbury for specialist investigations promptly when they received the radiography report.

6. After his diagnosis, prison healthcare staff fully supported Mr Astbury. The clinical reviewer concluded that Mr Astbury's care was equivalent to that he could have expected to receive in the community and we are satisfied that Mr Astbury received good care at Stafford.

The Investigation Process

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

8. The investigator obtained copies of relevant extracts from Mr Astbury's prison and medical records.

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

10. We informed HM Coroner for Stafford of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officer contacted Mr Astbury's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. His sister wanted to know whether there had been a delay in the diagnosis.

12. The investigation has assessed the main issues involved in Mr Astbury'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.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

14. Mr Astbury's brother and sister received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Stafford

15. HMP Stafford is a medium security prison, which holds more than 700 prisoners convicted of sexual offences. Staffordshire and Stoke-on-Trent Partnership NHS Trust provides healthcare services. There are no inpatient facilities. Nurses are on duty daily between 7.45am and 5.30pm. There is a weekday GP service, with an on-call service outside these hours.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Stafford was in February 2016. The report has yet to be published, but inspectors told us that primary care services were reasonably good.

Independent Monitoring Board

17. 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 April 2015, the IMB reported that there had been an increase in the number of older prisoners with health problems and long-term conditions. Additional funding had been used to buy equipment and recruit healthcare assistants, but the GP waiting list had increased significantly and it was not always possible to see everyone on the list within a week. The prison was considering adapting part of a wing, to facilitate end of life care.

Previous deaths at HMP Stafford

18. There have been five deaths from natural causes, at Stafford, since the beginning of 2015. Two of the other deaths are still under investigation. There were no significant similarities with the circumstances of the deaths we have already investigated.

Findings

The diagnosis of Mr Astbury's terminal illness and informing him of his condition

19. On 7 June 2011, Mr John Astbury was sentenced to 15 years in prison for sexual offences. He had been at HMP Stafford since16 September 2015. Mr Astbury reported no significant health concerns at his initial health screen and other than regular monitoring of his blood pressure, there were no significant entries in his previous health records.

20. On 29 September, Mr Astbury told a prison GP that he had a persistent, productive cough, which sometimes contained blood. The GP noted that Mr Astbury had given up smoking 14 years earlier, and that he was short of breath. Mr Astbury's blood oxygen concentrations were near normal at 97%, but he had reduced air entry in the upper lobe of the right lung. The GP made an urgent referral for a chest X-ray, which Mr Astbury had the next day.

21. On 1 October, a hospital radiologist noted the results of the X-ray indicated a malignancy and recommended that the prison make an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. However, the hospital did not fax the radiology report to the prison until 13 October. Healthcare staff acted on this within 24 hours. A prison GP explained to Mr Astbury that the X-ray results suggested lung cancer and that he had referred him to a specialist.

22. On 22 October, a nurse spoke to Mr Astbury about his possible cancer diagnosis. They discussed his diet, location and walking aids. She gave him information about lung cancer.

23. On 28 October, Mr Astbury had a CT scan at Stafford County Hospital. On 3 November, the nurse again offered him support but noted that he did not want to discuss the clinical detail.

24. On 9 November, the hospital specialists confirmed that Mr Astbury had bronchogenic carcinoma (lung cancer) that appeared to have spread to his liver. On 13 November, after discussing this with the specialists, a prison GP told Mr Astbury of this diagnosis.

25. When Mr Astbury initially reported a persistent cough, a prison GP quickly referred him for a chest X-ray but the hospital did not inform the prison of the radiologist's recommendation for an urgent specialist referral, until twelve days later. Hospital care is outside the remit of this investigation, but the clinical reviewer had made a recommendation to the NHS about this delay. However, he noted that Mr Astbury received treatment within NHS target times after first referral and did not consider the delay affected the outcome for Mr Astbury, as the cancer was advanced. We are satisfied that prison healthcare staff referred Mr Astbury for specialist investigation when indicated.

Mr Astbury's clinical care

26. On 18 November, a consultant told Mr Astbury that the cancer was not curable and his care would be palliative. On 20 November, a nurse spoke to Mr Astbury, who said he did not want to talk about his condition or prognosis.

27. On 24 November, Mr Astbury began his first round of palliative chemotherapy. The next day, a nurse created a care plan noting he did not want to discuss details of his condition and that Nurse A was the lead nurse. Healthcare staff maintained and updated the care plan throughout his illness.

28. On 17 December, Mr Astbury started a second round of chemotherapy. At a care plan meeting on 22 December, Nurse A reported that Mr Astbury was eating and drinking normally, and attending education classes.

29. On 25 December, Nurse A noted Mr Astbury had experienced more nausea and had difficulty managing his medication. She updated his care plan, noting that nurses should give him his medication but he should keep small amounts of pain relief medication in his possession.

30. On 8 January 2016, a prison GP and Nurse A examined Mr Astbury, who showed signs of sepsis and arranged for him to be assessed in hospital that day. Mr Astbury returned to the prison in the early hours of 9 January, after being treated with antibiotics. The oncologist cancelled the third cycle of chemotherapy, as Mr Astbury was too unwell to continue.

31. A prisoner carer checked Mr Astbury hourly to support him and ensure his fluid intake was sufficient. On 15 January, at a care plan meeting, Nurse A noted that Mr Astbury was increasingly fatigued and officers should check him frequently. That day, Mr Astbury told a Macmillan nurse and Nurse A that he did not want anyone to resuscitate him if his heart or breathing stopped. On 21 January, a prison GP formally recorded this decision and prescribed a fentanyl patch (strong pain relief medication).

32. On 22 January, the Macmillan nurse reviewed Mr Astbury and wrote a comprehensive palliative care plan focusing on his physical issues, emotional support and preserving his dignity.

33. By 27 January, Mr Astbury's condition had deteriorated and the Macmillan nurse and a nurse consultant in palliative care decided he needed full time nursing care. He was admitted to hospital for a short time that evening and given intravenous fluids to rehydrate him.

34. Mr Astbury's condition continued to decline and he was admitted to a hospice on 1 February, for end of life care. He died at the hospice on the evening of 6 February. The coroner gave the cause of death as metastatic small cell lung cancer.

35. After his diagnosis, prison and healthcare staff fully supported Mr Astbury. They were aware that Mr Astbury did not want detailed information about his condition, and dealt with this sensitively. We are satisfied that Mr Astbury received good

care at Stafford, equivalent to that he could have expected to receive in the community.

Mr Astbury's location

36. After his diagnosis, and at his request, Mr Astbury stayed in his shared cell, where he said he felt comfortable, had the support of his cellmate and friends and got on well with the prison staff. When he started chemotherapy, he moved to a single cell on the same wing to reduce the risk of infection. He was given a perching stool, raised toilet seat, a mattress to avoid pressure sores and a wrist-worn alarm.

37. Mr Astbury wanted to continue to care for himself as much as possible, but towards the end of December, agreed that a prisoner carer should help clean his cell and collect his meals for him. The carer continued to support him until he moved to a hospice for the last week of his life. We are satisfied Mr Astbury was appropriate accommodation during his illness and that the prison took into account his preferences.

Restraints, security and escorts

38. When prisoners have to travel outside prison, a risk assessment is undertaken to determine the nature and level of any security arrangements, including any restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

39. Risk assessments clearly stated that Mr Astbury was very frail and should not be restrained. We are pleased to note he was not restrained for any hospital appointments during his illness or when he was moved to the hospice.

Liaison with Mr Astbury's family

40. On 23 November, the prison appointed a Supervising Officer (SO) as their family liaison officer. She introduced herself to Mr Astbury and, after he agreed, she contacted his sister to inform her of his diagnosis and offer support. She kept in contact with Mr Astbury's sister and arranged for his sister and one of his brothers to visit him and the nurses who were responsible for his care.

41. When Mr Astbury died, hospice staff informed his family by telephone before informing the prison. The SO and a prison manager went to the hospice and offered Mr Astbury's family condolences and support.

42. Mr Astbury's funeral was on 16 February. The prison contributed to the costs in line with national instructions. The SO kept in contact with Mr Astbury's sister until after a memorial service at the prison, on 21 March. Members of Mr Astbury's family, prisoners, nurses and prison staff attended the service.

43. We are satisfied there was good liaison with Mr Astbury's family, who acknowledged the support they had received from the SO. In December 2015, Mr Astbury had written a letter of appreciation to the Governor, praising the way staff had treated him and his family.

Compassionate release

44. 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.

45. After Mr Astbury's diagnosis, the prison started an application for compassionate release but on 30 November, a prison GP said he could not give a clear prognosis so they did not proceed with the application at the time. On 16 January, the GP updated the application, which was submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service on 19 January.

46. The prison had not received a decision about the compassionate release application before Mr Astbury died, but received the decision shortly afterwards, rejecting the application on the grounds of risk to the public. We are satisfied that the prison appropriately considered compassionate release.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141