Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Duncan Smith a prisoner at HMP Usk on 19 January 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 Duncan Smith died of lung cancer on 19 January 2016, while a prisoner at HMP Usk. He was 71 years old. I offer my condolences to his family and friends.

Towards the end of October 2015, other prisoners were concerned that Mr Smith, who was a very heavy smoker, had a bad cough. Mr Smith assured a nurse that the cough was only occasional, and the nurse's examination found no other concerns about his health. The nurse did not arrange a GP chest examination, which would have been good practice, and might have led to a specialist referral for suspected cancer. However, Health Inspectorate Wales noted that a delay in diagnosis would not have altered the outcome for Mr Smith, as he appeared to have hidden his symptoms for some time and the cancer was very advanced when diagnosed in January. I am therefore satisfied that staff at Usk could not have prevented Mr Smith's death. While Health Inspectorate Wales considered that Mr Smith's care at the prison was equivalent to that he could have expected to receive in the community, they identified some concerns about communication from the hospital, which is outside the remit of my investigation.

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 **October 2016**

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Summary

Events

1. In December 2008, Mr Duncan Smith was sentenced to 14 years in prison for sexual offences. He had been at Usk since February 2014. He had high blood pressure and heart disease, which were well managed at the prison. He smoked heavily and consistently refused all advice and help to stop.

2. In October 2015, Mr Smith's prisoner carer noted he had a persistent cough. However, on 29 October, Mr Smith told a nurse that his cough was only occasional. At the end of November, Mr Smith complained of shoulder pain and a prison GP arranged a routine X-ray for 30 December. On 23 December, Mr Smith reported increasing shoulder and chest pain and a GP also arranged a chest X-ray.

3. On 30 December, a prison GP arranged for Mr Smith to be admitted to hospital after abnormal blood tests and an apparent deterioration in his health. The hospital discharged him the next day. It is not clear whether Mr Smith had the scheduled X-rays or other treatment, as the hospital did not send a discharge summary. (On 5 January 2016, X-ray results were entered in his medical record, showing an abnormality in his left lung, which needed investigation.)

4. On 4 January 2016, Mr Smith collapsed in his cell and was re-admitted to hospital. The hospital discharged him on 8 January, again without any discharge information about his condition and treatment. Mr Smith's condition continued to deteriorate. On 11 January, he was taken to hospital as an emergency. In hospital, doctors diagnosed terminal lung cancer, which had spread to his bones. Mr Smith remained in hospital for palliative care. He died in hospital on 19 January.

Findings

5. Although Mr Smith played down his symptoms, Healthcare Inspectorate Wales (HIW) considered that the nurse who saw him on 29 October should have referred him to a GP for a chest examination. HIW was satisfied that healthcare staff had already recognised this as a learning point, and changed their practice, so we do not make a formal recommendation. Had Mr Smith's persistent cough, coupled with shoulder pain, been identified, this should have triggered an urgent referral to a specialist. However, it seems that Mr Smith had hidden his symptoms for some time. As his cancer was very advanced, an earlier diagnosis after October 2015 is unlikely to have changed the outcome. HIW noted some deficiencies in hospital care. This is outside the remit of the PPO investigation, but HIW has made recommendations to the Health Board. These issues would not have affected the outcome for Mr Smith. HIW was satisfied that Mr Smith's care at Usk was equivalent to that he could have expected to receive in the community.

The Investigation Process

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

7. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records. He interviewed one prisoner by telephone on 17 February 2016

8. Healthcare Inspectorate Wales (HIW) reviewed Mr Smith's clinical care at the prison and interviewed two members of staff on 15 February and one on 17 February. HIW identified some concerns about communication between the hospital and the prison and had made recommendations, some of which the Head of Healthcare will need to address. We do not repeat them here, as this issue was not directly related to Mr Smith's death.

9. We informed HM Coroner for Gwent of the investigation who gave us the results of a non-invasive post-mortem examination. We have sent the coroner a copy of this report. Our investigation was suspended until we received the results of the post-mortem examination. We regret the consequent delay in issuing this report.

10. One of the Ombudsman's family liaison officers contacted friends of Mr Smith's, who he had named as his next of kin, to explain the investigation. They had no specific matters they wanted the investigation to consider.

11. The investigation has assessed the main issues involved in Mr Smith'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.

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

13. One of Mr Smith's friends received a copy of the initial report. They did not make any comments.

Background Information

HMP Usk

14. HMP Usk holds up to 273 men convicted of sexual offences. The prison is managed jointly with nearby HMP Prescoed. The Aneurin Bevan Local Health Board delivers healthcare services at Usk. Nurses are on duty from 8.00am to 4.30pm, Mondays to Fridays. There is a GP surgery every weekday morning and doctors are on call until 6.30pm each weekday. Out of hours and weekend services are provided through the Gwent Out of Hours Cover, which provides telephone triage and signposting by a nurse or doctor.

HM Inspectorate of Prisons

15. The most recent inspection of Usk was in May 2013. Inspectors were generally very positive about the prison but noted that relationships between staff and prisoners had deteriorated since the last inspection. Prisoners were positive about health services and inspectors noted there was a good service with regular GP clinics. Prisoners could see nurses each weekday at triage clinics and inspectors noted clinically thorough and polite consultations. Inspectors reported that the palliative care policy was inadequate, though the prison was developing a new policy.

Independent Monitoring Board

16. 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 2014/2015, the IMB noted that healthcare services had been remodelled, after responsibility for services had transferred to the local health authority. There had also been an increase in nursing staff. Recommendations from a Prison and Probation Ombudsman's investigation into a death at the prison, during the year, had been implemented.

Previous deaths at HMP Usk

17. Mr Smith was the fifth person to die from natural causes at HMP Usk since January 2014. There were no similarities between the circumstances of Mr Smith's death and the previous deaths at the prison.

Findings

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

18. In December 2008, Mr Duncan Smith was sentenced to 14 years in prison for sexual offences. He had been at Usk since February 2014. Mr Smith suffered from high blood pressure and ischaemic heart disease. Both were well managed. He had undergone a triple heart bypass operation in 2006 and received regular long-term medication. Mr Smith was a lifelong, heavy smoker and smoked about 50 cigarettes a day. He consistently refused advice and help to stop.

19. In October 2015, Mr Smith's cellmate and his carer (another prisoner who helped him with daily living tasks) noted that Mr Smith had a persistent cough. Mr Smith told them that he did not plan to do anything about it. On 27 October, a nurse examined Mr Smith, after his carer said he was concerned about the cough. Mr Smith said he felt well and had only an occasional cough. Mr Smith's pulse and blood pressure were both normal and the nurse told Mr Smith to come back if he had further problems. She did not refer him to a GP.

20. On 25 November, a prison GP examined Mr Smith, who had shoulder pain. She arranged a non-urgent X-ray of his shoulder for 30 December and prescribed a pain relief gel. In December, Mr Smith continued to report shoulder pain. Nurses noted that he was waiting for an X-ray.

21. On 23 December, Mr Smith told a prison GP that he had left sided chest pain, as well as the ongoing pain in his shoulder. His oxygen saturation and pulse rate were normal and she considered Mr Smith might have a respiratory tract infection. She arranged blood tests, a kidney function test, and a chest X-ray for 30 December, at the same time as the shoulder X-ray.

22. The results of the blood tests, recorded on 29 December, showed that his white blood cell count was raised and his CRP reactive protein count (which indicates a possible infection or inflammation) was very high. On 30 December, a prison GP reviewed Mr Smith and sent him to hospital, as she was concerned about the abnormal blood tests and that his physical condition had deteriorated. The next day, the hospital discharged Mr Smith but did not send a discharge summary to the prison. There is no record that anyone followed this up.

23. On 4 January 2016, Mr Smith collapsed in his cell. A prison GP examined him and arranged his admission to hospital. The next day, the X-ray results were entered in Mr Smith's records. These showed no shoulder abnormality, but an abnormality in his left lung, which needed further investigation. There is no record when the X-rays were taken, but it is possible this was on 30 December when he was in hospital. On 8 January, the hospital discharged Mr Smith without a discharge summary.

24. On 11 January, a prison GP noted that Mr Smith was increasingly unwell, exhausted and had very poor oxygen intake. The GP sent him back to hospital and he was admitted for further tests, which found he had lung cancer. That afternoon, a consultant informed Mr Smith that he had terminal lung cancer, which had spread to his bones.

25. The National Institute for Health and Care Excellence (NICE) quality standards for lung cancer says that an unexplained cough lasting more than three weeks should be investigated, as should chest and shoulder pain. However, Mr Smith played his symptoms down, and did not report a persistent cough. Nevertheless, HIW considered that it would have been good practice to have referred him to a GP for a chest examination. (HIW noted that healthcare staff had already identified this as a learning point from Mr Smith's death, so we do not make a formal recommendation.) Combined with his shoulder pain, this should have led to an urgent referral to a specialist for suspected cancer. HIW concluded that it was likely that Mr Smith had hidden his symptoms for some time, as his cancer was very advanced when diagnosed and an earlier diagnosis in November, is unlikely to have affected the outcome. While an earlier diagnosis might have been possible, we are satisfied that the prison has addressed this matter.

Mr Smith's clinical care

26. On 11 January, a hospital nurse informed prison healthcare staff that the cancer had spread to Mr Smith's bones and his prognosis was poor. All of Mr Smith's treatment after his diagnosis was in hospital, which is outside the remit of this investigation. Mr Smith remained in hospital and clinicians treated him palliatively. His condition declined very quickly and he died on 19 January.

27. A non-invasive post-mortem concluded that Mr Smith had died from metastatic adenocarcinoma of the lung (lung cancer that had spread to other parts of the body).

28. HIW was satisfied that Mr Smith received appropriate care at the prison but had some concerns about the appropriateness of hospital discharges, at the end of December and in early January. As noted, hospital care is not within our remit, but HIW has made recommendations to the Local Health Board, some of which the Head of Healthcare will need to address with the hospital.

Mr Smith's location

29. Mr Smith had a shared cell on a standard wing at Usk. Initially, he had the top bunk, but when he began to suffer from shoulder pain, he moved to the bottom bunk.

30. Each time Mr Smith was discharged from hospital, prison healthcare staff assessed his needs. As his health deteriorated, they were concerned that he needed 24 hour medical care, which was not available at Usk and made initial enquiries with HMP Cardiff and HMP Parc. When Mr Smith went to hospital on 11 January he remained there until he died.

31. We are satisfied that Mr Smith was appropriately located during his time at Usk. Healthcare staff considered his needs and were investigating alternative locations for him at the time of his death.

Restraints, security and escorts

32. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including 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 and should be kept under review as circumstances change.

33. When Mr Smith went to hospital as an emergency on 11 January, a prison manager assessed him as a low risk to the public and of escape but decided that he should be restrained by handcuffs. There was no input from prison healthcare staff to the risk assessment. Once Mr Smith arrived at hospital, the manager reviewed the risk assessment in the light of information from hospital clinicians. He agreed that officers should remove the restraints. Mr Smith was not restrained again.

34. While it seems unlikely that restraints were necessary when Mr Smith was first taken to hospital, we are satisfied that this decision was reviewed quickly and that restraints were removed promptly once there was further information about Mr Smith's medical condition.

Liaison with Mr Smith's next of kin

35. Mr Smith had no contact with his family and had named two friends as his next of kin, although he had little contact with then during his time in prison. On 9 December, the prison appointed a Supervising Officer (SO) as Mr Smith's family liaison officer. She arranged for Mr Smith to telephone his friends and he told them he had been in hospital and was unwell. She remained in contact with Mr Smith's friends during his illness.

36. On 18 January, when Mr Smith was reaching the end of his life, the SO telephoned Mr Smith's friends to inform them. They asked her to telephone them when he died. During the afternoon, Mr Smith received messages and prayers from his friends, through the prison chaplain.

37. When Mr Smith died, the SO telephoned his friends and offered condolences and support. The next day, another family liaison officer and a prison manager arranged to visit them on 21 January. In line with national policy, the prison arranged and paid for Mr Smith's funeral.

Compassionate release

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

39. As Mr Smith's terminal cancer was diagnosed just over a week before he died, there was insufficient time to make and consider an application for compassionate release.

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