Investigation into the circumstances surrounding the death of a man in March 2011 at a hospice, while a prisoner HMP Altcourse

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the death of a man who died of lung cancer in a hospice in March 2011 while a prisoner at HMP Altcourse. He was 57 years of age. I extend my condolences to his family.

An investigation was carried out and, given that the man's death was foreseeable, it is appropriately brief and focused on key issues. The local Primary Care Trust (PCT) commissioned a clinical review into the medical care that the man received in prison custody and this was carried out by a clinical reviewer. I am grateful to him and the Director and staff of Altcourse for their co-operation with the investigation. I apologise for the delay in issuing this report.

The clinical reviewer observed that the man's health was relatively stable until August 2010, when he complained of chest pain. A doctor diagnosed that the pain, was not heart related. In February 2011, he told a doctor that he had become increasingly breathless. An x-ray the following day, showed fluid on the lungs and he was admitted to outside hospital. A week later, hospital staff discovered that he also had fluid round his heart and that the cause was lung cancer. The disease was at such an advanced stage that the consultant offered only palliative care.

The man remained in hospital and senior prison managers initiated an application for Release on Temporary Licence and early release on compassionate grounds. The former was granted on 4 March and he transferred to the hospice. The request for compassionate release was still being processed when he died.

The clinical reviewer concludes that the care given to the man at Altcourse was equivalent to that which he could have expected to receive in the community. However, it is unclear whether he was given the help he requested to stop smoking and a recommendation is made to ensure prisoners are referred to appropriate clinics and that this is recorded. He also told a nurse during a check-up that his father had angina but, when he later complained of chest pain, the doctor he saw noted that there was no cardiac history in the family. A recommendation is therefore made that doctors make full use of electronic records during consultations. Finally, it appears that staff should have conducted a fresh security risk assessment of the required level of escort security once his condition was diagnosed as terminal and a recommendation is made to this effect.

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.

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Prisons and Probation Ombudsman **November 2012**

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SUMMARY

1. The man was remanded into custody at HMP Altcourse on 3 October 2009 and was bailed five days later. On 26 February 2010, he was sentenced to three years' imprisonment and returned to Altcourse. He told a nurse in reception that he was a smoker but wanted to stop. There is no record of whether staff referred him to smoking cessation classes. However, at another health assessment a few months later, on 7 June, he said he did not want to give up smoking.

2. On 10 August, the man reported chest pain to a doctor, which he said had started the previous day while he was at work. The pain was worse when he moved and eased when he rested. The doctor wrote in the records that he was not breathless and there was no cardiac history in his family. (Although an entry made by a nurse six months previously, on 28 February, noted that his father had suffered from angina.) The doctor examined him and diagnosed, "Non cardiac chest pain - musculoskeletal chest wall pain", which is pain that is felt in the muscles or bones of the body. He advised him to rest for a few days and prescribed 28 days of anti-inflammatory medication.

3. The man told a nurse on 12 February 2011 that he had become increasingly breathless since the previous November. The nurse put him on the waiting list for an appointment with a doctor and he was assessed three days later. The doctor ordered a number of tests, including an x-ray.

4. Later that day, the man went to outside hospital to have the x-ray, which showed fluid on his lungs. He was admitted to the hospital to have further tests and an operation to remove the fluid from his lungs. The results of the tests showed that he had metastatic lung disease. (Metastatic means that the cancer had spread from his lungs to other organs in his body.) The hospital consultant said that the cancer was so advanced that no treatment available and his life expectancy was less than three months. However, they would provide palliative care.

5. Senior managers at the prison arranged for the man to be released on temporary licence and hospital staff arranged to transfer him to a hospice near his family. They also applied for release on compassionate grounds because of the poor prognosis but he died before a decision was made. He moved to the hospice on 4 March, where he died several days later.

6. The investigation has concluded that the care given to the man was both timely and appropriate and at least the equivalent of that expected in the community. Recommendations have been made regarding referring prisoners to appropriate clinics and conducting further risk assessments when a prisoner is diagnosed with a terminal illness.

THE INVESTIGATION PROCES

7. A senior investigator conducted the investigation into the man's death. She visited HMP Altcourse, including the healthcare centre Reynoldstown unit, where he had previously spent most of his stay. She spoke to several staff, including Altcourse's family liaison officer who had been in contact with his family. She studied all relevant prison records relating to him, including his clinical records.

8. The local PCT commissioned a clinical reviewer to carry out a clinical review of the healthcare the man received.

9. The investigator contacted HM Coroner to inform him of the nature and scope of the investigation. A copy of this report will be sent to him to assist with his enquiries. We apologise for the delay in issuing the report, which was due to workload pressures.

10. One of our family liaison officers spoke to the man's family to explain the investigation process and learn of any questions or concerns they wish to be considered. His family raised a number of issues:

    - Why had the family not been told by prison managers that he was in hospital?
    - He told his family he had tried to see a doctor on numerous occasions before he collapsed but was unsuccessful.

11. As the man's death was, sadly, foreseeable the investigation took a proportionate approach and does not set out a detailed chronology of events. Instead, a thematic approach was taken to assesses the following aspects of his care and treatment:

    - Whether his diagnosis was made in a timely fashion?
    - Whether he was told about his condition and the options for treatment?
    - Whether he was given appropriate pain relief?
    - Whether the liaison with his family was appropriate?
    - Whether he was accommodated in the most appropriate part of the prison?
    - Whether consideration was given to compassionate release from prison?

HMP ALTCOURSE

12. HMP Altcourse was the first prison in the United Kingdom to be designed, financed and managed under a contract by a private company. It is managed by G4S custodial services and has been open since 1997. The prison can hold up to 1,324 adult men and young offenders and covers North Wales, Merseyside and Cheshire.

13. G4S has provided healthcare services in-house at Altcourse since August 2009. HM Chief Inspector of Prisons (HMCIP) last published an inspection report of Altcourse in March 2010. It described Altcourse as a safe prison with adequate healthcare "but staff shortages and a recent lack of leadership had impacted on services".

14. Each prison has its own Independent Monitoring Board (IMB), which comprises unpaid volunteers from the local community appointed by the Secretary of State for Justice. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State for Justice. In its report focussing on the time period June 2009 to June 2010, the IMB at Altcourse said:

    > "Healthcare now provided 'in-house' [by G4S] continues to improve… whilst there were initially some minor 'teething' problems, the change-over was well managed and went relatively smoothly. The board believe overall this change of control has improved the healthcare services being delivered to prisoners."

15. There have been five previous deaths attributed to cancer at Altcourse since the Ombudsman was given the responsibility for investigating all deaths in prison custody in 2004. We do not believe there are any significant common features between this investigation and those into any of the previous deaths.

ISSUES

Background

16. The man was remanded into custody at HMP Altcourse on 3 October 2009. In Admissions, a nurse examined him and checked his medical history. He said that he had no mental or physical health issues and did not drink alcohol. He admitted that he had used cannabis for 38 years. The nurse recorded his weight as nine stones two pounds and noted that his ideal weight for his height would be 11 stones 5 pounds. As it was his first time in prison, the nurse referred him to a registered mental nurse (RMN). This appointment did not take place as he was given bail on 8 October.

17. On 26 February 2010, the man was convicted of the manufacture of cannabis and possession with intent to supply and was sentenced to three years' imprisonment. He returned to Altcourse, where the nurse in Admissions noted he had put on weight but was still almost a stone under his ideal weight. Two days later, at a well man check, he said that he smoked 20 cigarettes a day but wanted to stop. There is no record of staff offering him help to give up smoking. The nurse wrote in the medical record that his father had a history of angina, a symptom of an underlying heart problem. He asked for appointments with a doctor and dentist. On 1 March, he had blood taken for a range of tests. The results showed that renal profile, liver function and blood count were all normal and no further action was necessary.

18. From March until the beginning of August, the man had several medical appointments with the doctor. He received anti-inflammatory medication, ibuprofen, for arthritis in his fingers, combined with an antacid pill to counter the side effects. He also received hospital treatment for a wart at a local Liverpool hospital.

The diagnosis of the man's terminal illness

19. On 10 August, the man reported chest pain to a doctor, which he said had started the previous day while he was at work. The pain was worse when he moved and eased when he rested. The doctor wrote in the records that he was not breathless and there was no cardiac history in his family. However, an entry made by a nurse six months previously, on 28 February, noted that his father had suffered from angina. There is no explanation for the discrepancy but a check of SystmOne records should have produced the information about his father, therefore we make the following recommendation:

    The Head of Healthcare should ensure that doctors make full use of computer records during consultations.

20. The doctor examined the man and noted, "ECG – normal. Chest: clear. HS Dual, no murmurs". (ECG stands for electrocardiogram, a simple and useful test that records the heart's electrical activity. A heart murmur is where the heartbeat has an extra, or unusual, sound. It is caused by a disturbed blood flow through the heart.)

21. The doctor diagnosed “Non cardiac chest pain - musculoskeletal chest wall pain”. This is pain that is felt in the muscles or bones of the body. He advised the man to rest for a few days and prescribed 28 days of anti-inflammatory medication.

22. The clinical reviewer discusses this diagnosis in paragraph 30 of his report. He states:

> “It is arguable that a chest X ray might have been considered on 10th August 2010 when the man presented with chest pain. However the doctor took the view that the patient’s symptoms could be explained and managed without the aid of a chest x ray at that stage. I take the view that this was a reasonable course of action.”

23. For the next six months, the man had a number of healthcare appointments. This was because he was monitored under a care plan for older prisoners, which the healthcare staff classify as men over the age of 55 years. His weight and blood pressure were checked.

24. The man continued to smoke cigarettes. At his health check on arrival in prison, he had told the nurse that he wanted to stop smoking. However, there is no record of staff offering him advice about and help with stopping smoking as a result. The investigator spoke to the current Head of Healthcare to ask what services would have been available when he arrived in prison.

25. At that time, smoking cessation classes were provided by a local charity through a programme called “Fag Ends”. The person who ran them used a notebook to record referrals and course participants, so there is no record of whether the man was put on the waiting list. We would have expected a note of any referral to have been noted on SystmOne, the computer system, but no referral is recorded. Last year, G4S took healthcare services in-house and since then referrals are made through SystmOne. Nevertheless, we make the following recommendation:

    The Head of Healthcare should ensure that staff refer prisoners to appropriate clinics and that such referrals are recorded in the medical records.

26. The man had a further health assessment on 7 June. The questions included whether he was a smoker. He said he was but this time he said that he did not want to stop and so was not referred to a smoking cessation clinic.

27. On 12 February 2011, the man told a nurse that he was feeling breathless after mild exertion. The nurse placed him on the waiting list to see a doctor, describing it as a “routine” appointment. He also gave him two days’ worth of paracetamol tablets for “pain/high temperature”. (He had complained the previous month of pain in his leg and had been given painkillers and a doctor’s appointment was made. He did not, however, keep the appointment.) A note in the medical record two days later states “29th on doctor”. Three days is

comparable to the time a person in the community would have to wait to get an appointment with their GP.

28. The following day, a doctor saw the man, who told him that he had become increasingly breathless since November. The doctor noted:

> "Noticed initially that he was puffed when walking up flight of stairs. However has now noticed, he can't even climb halfway up the stairs before having to stop for breath."

29. The doctor recorded that the man said he had smoked three ounces of tobacco a day for almost 40 years but had now cut down. The doctor ordered a spirometry test, which was normal. (Spirometry measures airflow. By measuring how much air someone exhales, and how quickly, spirometry can evaluate a broad range of lung diseases.) He also asked for blood tests and a chest x-ray.

30. The man was taken to the Accident and Emergency Department at hospital later the same day, to have the chest x-ray. The result showed that he had bilateral pleural effusions. (A pleural effusion is a collection of fluid next to the lung, which might cause a person to become breathless. There are various causes. Bilateral means that the effusions were on both lungs.) Because of this, he was admitted to the hospital to have a procedure called a "bilateral fusion torsion" (draining the fluid on the lungs). Hospital staff told the prison healthcare staff that they expected him to be in hospital for about a week.

31. On 23 February, another of the prison doctors spoke to one of the hospital doctors treating the man. The results of the computerised tomography (CT) scan and other tests showed that he also had a pericardial effusion, fluid around the heart. (A CT scan is a detailed x-ray of the internal organs of the body.) The cause of this was probably cancer. He told the doctor that their team was holding a meeting the next day to discuss the results and a treatment plan and he would provide more information after that.

32. The following day, the prison doctor spoke to the hospital consultant who was treating the man. The test results showed that he had metastasic lung disease as well as the pleural infusions. (Metastatic means that the cancer had spread from his lungs to other organs in his body.) The consultant said that the cancer was so advanced that there was no treatment available. He needed palliative care and his life expectancy was less than three months.

33. The doctor who examined the man in August 2010 when he first reported chest pain, made a decision based on how he presented at the time and took a particular course of action. He did not return with persistent symptoms following that consultation. A chest x-ray might well have led to a different diagnosis. However, in the circumstances, it would be unreasonable to dispute the doctor's judgement solely with the benefit of hindsight. We therefore agree with the clinical reviewer that the doctor's actions were reasonable and are satisfied that his cancer was diagnosed without undue delay. It is disappointing

that the note of the family history of a cardiac condition was missed at that appointment but this does not appear to have affected the outcome for him.

Informing the man about his condition and treatment

34. The doctor made an entry in the man's medical notes on 24 February after he had spoken to the consultant. After the medical facts, he wrote, "Wishes to go to his father's house in Yorkshire or even a hospice closer to his fathers place".

35. Given that the man was in hospital, it appears that it was hospital staff who broke the news of his cancer to him and discussed what he would like to do. His care in hospital does not fall within our remit. He remained in hospital while prison managers applied for permission to release him on temporary licence to a hospice.

The man's medical appointments and treatment

36. After his diagnosis, the man remained in hospital until his transfer to Barnsley Hospice on 4 March, having been released on temporary licence (ROTL). Therefore, he had no further medical appointments. His treatment was the responsibility of the hospital and hospice staff until he died. The clinical reviewer considers that prior to his admission to hospital, his clinical care was equivalent to that which he could have expected in the community and we concur with his view.

The man's pain relief and medication

37. The hospital and then hospice staff were responsible for ensuring that the man suffered as little pain as possible.

Liaison with the man's family

38. When the man was initially admitted to hospital on 15 February, a decision was taken, on the basis of the risk assessment, that he should not be allowed visitors. However, the following day, when it became clear that his condition was serious, the prison allowed him to telephone his brother. Further telephone calls to other family members were authorised during the remainder of his stay and visitors were permitted from 26 February.

39. The man's next-of-kin was his father but, because he is elderly, the prison's family liaison officer telephoned his brother first after his death. He then spoke to the man's father. He visited the family on 16 March, when he met the man's former wife. He offered assistance with the funeral expenses and asked whether they would like to visit the prison, which they declined.

The man's location

40. The man remained in outside hospital from the time of his diagnosis until he transferred to a hospice. Sadly, he died before a decision was made about whether he would be released on compassionate grounds.

Compassionate release

41. After speaking to the consultant on 24 February, the doctor informed prison managers of the man's condition and very poor life expectancy. He then wrote to the consultant asking him to confirm the man's prognosis in writing. The letter was faxed to the consultant the following day. His reply was received on 2 March.

42. Prison managers began the process of applying for ROTL and Early Release on Compassionate Grounds. For ROTL, a risk assessment was completed and three managers held a meeting on 2 March. They recommended that the man could be released on temporary licence to a hospice and the Controller agreed. (In prisons managed by the private sector, a civil servant called a controller, equivalent to a governor grade, is employed by the Ministry of Justice to ensure that the terms of the private company's contract with the government are adhered to.) On 4 March, a place at a hospice became available and he transferred there from the hospital, without returning to the prison.

43. Unlike the decision for ROTL, which is decided by the Controller, Early Release on Compassionate Grounds is a decision taken the Secretary of State, taking into account information provided by the prison and medical opinions

44. Guidance in Prison Service Order 6000 – Parole, Release and Recall, Chapter 12, advises that early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is only granted in exceptional circumstances.

45. The fundamental principles underlying the approach to early release on compassionate grounds are:

    - The release of the prisoner will not put the safety of the public at risk.
    - A decision to approve release would not normally be made on the basis of fats of which the sentencing or appeal court was aware.
    - There is some specific purpose to be served by early release.

46. Early release may be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits but three months is considered to be an appropriate period. A clear medical opinion on the likely life expectancy is required. The Secretary of State also has to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside

prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family.

47. The Director of Altcourse collected statements from the consultant, the man's prison probation officer and various documents related to his offences and sentence. He recommended that he should be given Early Release and the file was faxed to the casework unit in the National Offender Manager Service, responsible for administering such applications, on 3 March.

48. Sadly, the man died in the hospice before a decision had been reached.

Palliative care plans

49. As noted above, the hospital and hospice staff were responsible for treating the man and ensuring that he suffered as little pain as possible.

Restraints, security and bed watch

50. Any prisoner required to remain in hospital, who has not been released from custody on temporary licence, is escorted and monitored by prison officers. This is known as a 'bedwatch'. This usually means that two officers remain at the bedside and record any significant changes or events. Subject to a risk assessment process, the prison Director decides whether the prisoner should be handcuffed and the number of officers required to stay with the prisoner.

51. The man's bedwatch logs show that when he left the prison he was escorted by two officers. He was wearing handcuffs and was also handcuffed to an officer. This is called being "double cuffed". The form that sets out the level of restraint contains the following warning, "LIDS [computer system] states drugs cuff to staff from [HMP Haverigg]".

52. The officers remained with him while he had tests and examinations. At 7.10pm, the officers asked for and received permission to remove the handcuffs and use an escort chain instead. This is a length of chain with a single handcuff at each end, one worn by the man and the other by an officer.

53. At various times over the next few days, the escort chain was removed while the man had tests and surgical procedures. On 1 March, five days after the cancer was diagnosed, one of the senior prison managers gave permission for the officers to remove the escort chain and reduced the escort to a single officer. Two days later, at 5.50pm, prison staff gave him the ROTL papers and his property. The staff then returned to Altcourse.

54. Decisions on what level of security to use when a prisoner goes to hospital are important as the prison has a responsibility to protect the public. However, there is also the dignity of the prisoner to consider, especially when the person is dying. On 24 February, the man's cancer was diagnosed as being untreatable and the consultant's opinion was that he had less than three months to live. Prison staff began the process of applying for ROTL and compassionate release. This would have been a good point at which to carry

out a new risk assessment and review the security level. The following recommendation is made on this issue:

The Director should ensure that managers carry out a fresh security risk assessment as soon as a prisoner in hospital is given a terminal diagnosis.

CONCLUSION

55. The man first reported chest pain in August 2010 and was treated with painkillers for non cardiac chest pain. Although the doctor who saw him does not appear to have considered the option of a chest x-ray at that point, there is no indication that he was negligent in his advice or action. He had routine health check ups in the following months.

56. Six months later, on 15 February 2011, when the man reported breathlessness, the same doctor arranged an x-ray and other tests. The x-ray was conducted as an emergency in an outside hospital on the same day as the consultation and. On the basis of the results, he was admitted to hospital without returning to the prison. Following further scans and tests, hospital doctors diagnosed cancer a week later.

57. The man did not return to the prison following his diagnosis, so his treatment in the last few weeks of his life did not come within the scope of this investigation. Prison managers approved temporary release to enable him to transfer to a hospice. They also applied, to the Secretary of State, for compassionate early release. Regrettably, he declined rapidly and died within a month of diagnosis, before a decision was made.

58. We consider that the actions of staff at Altcourse were timely and appropriate in seeking a substantive diagnosis. We are also pleased to note the attempts to secure the man's release. However, we believe that consideration could have been given to removing his restraints at an earlier point in his stay at hospital, soon after his diagnosis. A recommendation has been made on this point.

59. During the course of the investigation, the investigator found that when the man first went into prison, he expressed a wish to give up smoking. There is no record of any action taken to address this. We have therefore made a recommendation on this issue. With the exception of this, the investigation has concluded that he received clinical care at Altcourse at least the equivalent of expectations in the community.

RECOMMENDATION

1. The Head of Healthcare must ensure that staff refer prisoners to appropriate clinics and that such referrals are recorded in the medical records.

   The recommendation was accepted. The prison response was:

   "The second reception process identifies, if applicable, clinics appropriate to individuals needs. The Head of Healthcare will ensure that effective recording of this process occurs."

2. The Director should ensure that managers carry out a fresh security risk assessment as soon as a prisoner in hospital is given a terminal diagnosis.

   The recommendation was accepted. The prison response was:

   "A risk assessment will be completed on any offender who is given a terminal diagnosis. This will be recorded appropriately and depending on the identified risk factors implemented accordingly. This will also prompt ROTL and Early Release on Compassionate grounds. This procedure will be incorporated into the Local Security Strategy."

3. The Head of Healthcare should ensure that doctors make full use of computer records during consultations.

   The recommendation was accepted. The prison response was:

   "System One is available to Doctors, who will input details from consultations onto System One. The Head of Healthcare will reinforce the importance of using previous records when considering treatment."