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 on 29 December 2014 while a prisoner at HMP Swaleside

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, from pancreatic cancer on 29 December 2014, while a prisoner at HMP Swaleside. He was 44 years old. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was released from a prison sentence in December 2010, but recalled in February 2011. He had been at Swaleside since May 2011. He had no serious health concerns until August 2014, when he began to lose weight. From September, he began to complain of stomach pains, which doctors investigated. On 11 November, a doctor made an urgent referral for suspected cancer. However, he became more unwell and was admitted to hospital on 17 November, before he had received a specialist appointment. On 21 November, hospital doctors diagnosed cancer. No active treatment was possible and the hospital discharged him back to the prison, on 3 December. On 27 December, he was admitted to hospital as an emergency and died two days later.

I am satisfied that the man's cancer was diagnosed appropriately and promptly. I agree with the clinical reviewer that the standard of healthcare the man received at Swaleside was equivalent to that he could have expected to receive in the community. However, I am concerned that he was restrained by double handcuffs in hospital, without fully taking into account his health and I am not satisfied that managers fully considered an application for compassionate release against the appropriate criteria.

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 **August 2015**

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SUMMARY

1. In December 2010, the man was released from prison on licence. His licence was revoked and he was recalled to prison in February 2011. He had been at Swaleside since May 2011.

2. The man began to report losing weight from December 2013, but healthcare staff monitored this and it remained stable until August 2014, when a doctor noted he had lost 2.6kg since May. The doctor requested urgent blood tests but these were not taken until a month later, because the man did not attend four earlier appointments. No one followed up his non-attendance. The eventual results showed only slight abnormalities.

3. From the end of September, the man began to complain of stomach pain. Doctors prescribed pain relief and medication to reduce stomach acid, which he did not always take. Tests results on 3 October, showed that he had stomach bacteria, for which the doctor had already prescribed antibiotics. However, the man had already decided to stop taking them. The doctor made a routine referral to a gastroenterologist. The clinical reviewer was satisfied that the man's symptoms at that stage did not justify an urgent referral.

4. In late October, he reported leg pain and hospital doctors diagnosed deep vein thrombosis. He continued to complain of stomach pain and blood tests showed his liver function was declining. On 11 November, a doctor referred him urgently to a specialist for suspected cancer. On 17 November, before he received the appointment, he became unwell and was admitted to hospital. On 21 November, hospital doctors diagnosed terminal pancreatic cancer.

5. When he went to hospital, managers decided that the man should be restrained by double handcuffs. From 26 November, a manager changed this to single handcuffs and an escort chain. The hospital discharged him on 3 December and he chose to return to his previous cell, where prison doctors and nurses reviewed him daily. On 19 December, a consultant told the man he had no more than six weeks to live. The Governor did not support an application for compassionate release. The man's condition deteriorated rapidly and, on 27 December, he was admitted to hospital. His family was with him when he died two days later, on 29 December.

6. We agree with the clinical reviewer that the man's care in prison was equivalent to that he could have expected to receive in the community. We are concerned that he was restrained in hospital without proper justification, and that an application for compassionate release did not proceed. We make two recommendations.

THE INVESTIGATION PROCESS

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

8. She obtained copies of the man's prison medical records and relevant extracts from his prison record. The investigator interviewed four members of staff at Swaleside on 26 February 2015.

9. NHS England commissioned a doctor to review the man's clinical care at the prison.

10. We informed HM Coroner for Mid Kent and Medway District of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's brother, his nominated next of kin to explain the investigation. His family were concerned he had not received appropriate palliative care, and wanted clarification about his diagnosis and treatment. They also provided excerpts written by the man about his care, and video footage of him in restraints, along with other pieces of evidence for the investigator to consider.

12. The investigation has assessed the main issues involved in his 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 prison have submitted an action plan detailing what they have done to address the issues we raised, and this is included at the end of the report. The man's family received a copy of the draft report. They are unhappy with the conclusion of the investigation and disagree that the standard of care he received was equivalent to that he could have expected to receive in the community. They believe that prison and medical records show staff could be dismissive and uncaring towards him. They have asked for an apology from the Governor, for being misinformed about the status of the application for Early Release on Compassionate Grounds. They remain adamant that greater efforts should have been made to determine the cause of his symptoms when he first became unwell in 2011.

HMP SWALESIDE

14. HMP Swaleside forms part of the Isle of Sheppey group of prisons which also includes Elmley and Standford Hill. Swaleside's main function is to hold life-sentenced prisoners, but it also holds prisoners serving determinate sentences. The prison can hold up to 1,112 men. Healthcare is provided by IC 24 Integrated Care. There is a GP run practice and inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of Swaleside was in May 2014. The Inspectorate found that prisoners had good access to primary care and mental health services and there was a good inpatient unit. However, non-attendance rates at GP and nurse-led clinics were high. All clinical areas were well equipped and suited to the care and treatment of patients. Hospital appointments were often cancelled at short notice because of a shortage of officers for escorts. Inspectors noted that there were good procedures for the care and management of prisoners who were terminally ill.

Independent Monitoring Board

16. 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 annual report for the year 2013-2014, the IMB was concerned that staff shortages had led to a large number of hospital appointments being cancelled, which was stressful for prisoners and costly for the NHS. The IMB commented that the healthcare area was always clean and staff were helpful.

Previous deaths at HMP Swaleside

17. The man was the fifth prisoner at Swaleside to die from natural causes since January 2013. We have raised the issue of the inadequately justified use of restraints before.

ISSUES

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

18. The man was released on licence in December 2010, but his licence was revoked on 17 February 2011. He had been at Swaleside since May 2011. At his initial health screen, he weighed 64kg and said he was concerned he was losing weight. Healthcare staff monitored his weight. In December 2013, when he said he was losing weight, a healthcare assistant weighed him as 64.6kg, half a kilogram heavier than in 2011. A prison GP referred him to a hospital dietician who saw him on 7 March 2014. The dietician suggested he ate more fruit and vegetables.

19. On 1 May 2014, the man complained of losing weight again and said he was passing a lot of wind. Another prison GP recorded his weight as 64.6kg, the same as in December 2013. The GP asked the catering department to give the man extra portions of fruit and vegetables and soya milk, to help relieve his symptoms.

20. On 15 August, a doctor saw the man, who again complained of losing weight. He now weighed 62kg, a loss of 2.6kg since May. The doctor requested blood tests and planned to review him after receiving the results. However, the man did not turn up for four separate appointments for blood tests. A healthcare assistant eventually took the blood tests on 18 September. The results showed slight abnormalities which might have indicated a mild iron deficiency.

21. The man missed further appointments with the doctor on 18, 19 and 22 September but attended on 25 September when he complained of abdominal pain. The doctor noted a further weight loss, recording his weight as 61.9kg. He prescribed nutritional drinks and lansoprazole (a medication to reduce stomach acid).

22. On 28 September, the man complained of stomach pain and a healthcare assistant took his clinical observations and noted his blood pressure, pulse and oxygen were all within normal range. She made an appointment with the doctor and the doctor saw the man on 30 September. The man said he could not sleep because of the pain and the doctor took a stool sample for tests to exclude helicobacter pylori (bacteria) and coeliac disease (a digestive and autoimmune disorder). He prescribed more lansoprazole. On October, a doctor prescribed antibiotics on 3 October and referred the man to a gastroenterologist. On 6 October, test results ruled out coeliac disease, but indicated helicobacter pylori, for which he was already prescribed antibiotics.

23. On 7 October, a doctor saw the man who complained of ongoing abdominal pain. He was not taking his medication because he thought it was not working and worried it was causing more damage. He now weighed 61kg. The doctor prescribed medication to relieve stomach cramps and for constipation. At a further appointment with the doctor on 9 October, the man asked for medication to reduce stomach acid. He told the doctor that he

thought he might have cancer and other illnesses, which he had read about. The doctor prescribed gaviscon and ranitidine (to treat heart burn and prevent stomach ulcers). The doctor noted that the man had been referred to a gastroenterologist and a dietician. (The gastroenterologist appointment was later scheduled for 13 November.)

24. On 11 October, a nurse examined the man, when he complained of having severe abdominal pain. She noted his temperature and blood pressure were within normal range and gave him pain relief medication. He complained of abdominal pain again on 13 October, and a nurse made a doctor's appointment. On 16 October, a doctor diagnosed an intestinal infection and planned a review ten days later, unless his symptoms became worse. He also prescribed antibiotics. The man now weighed 59.6kg (1.4kg less the 7 October).

25. At the end of October he had leg pain. He attended hospital as an outpatient on 30 and 31 October, and doctors diagnosed deep vein thrombosis (DVT). The hospital prescribed warfarin injections (anticoagulant) and co-codamol for pain relief. Evidence provided by the man's family, show that he was unhappy with his treatment for DVT within the prison. The clinical reviewer was asked to consider this, and raised no concerns about the DVT treatment.

26. Over the next few days, prison doctors reviewed the man and carried out blood tests, which showed deteriorating liver function. Doctors planned a scan of his liver to investigate the cause of the abdominal pain. On 3 November, a doctor saw the man and noted the hospital DVT clinic had referred him for further investigation, because he had no known risk factors for DVT. A prison GP saw him on 4 November and prescribed buprenorphine patches (opiod pain relief) for his stomach pains.

27. On Monday 10 November, the man told a doctor that he had a lot of pain in his sides and back, but had not received pain relief over the weekend as the pharmacy had cancelled the patch prescription because the doctor had not considered alternative options. (Pain relief patches in prison are easily diverted for illicit use and are not recommended as safe prescribing practice.) The excerpts from the man's diary show that he was very unhappy with the lack of pain relief provided at the start of November. The clinical reviewer was asked to review his care, and stated that overall the pain relief the man received was adequate. A doctor recorded the man's temperature and blood pressure as within normal range, but his pulse rate was high. The doctor prescribed tramadol for pain relief. The next day, 11 November, a doctor reviewed blood test results, which showed continued deteriorating liver function. He made an urgent referral to a colorectal clinic under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

28. On 13 November, a consultant gastroenterologist saw the man in relation to the earlier referral and arranged upper and lower gastrointestinal endoscopies and a CT scan of his chest, abdomen and pelvis.

29. On 17 November (before the hospital had made the specialist colorectal appointment and before the tests arranged by the gastroenterologist) a doctor considered that the man appeared to very unwell and arranged his admission to hospital. On 21 November, after specialist pathology tests, hospital doctors diagnosed pancreatic cancer, which had spread to his liver. Hospital doctors informed him. He telephoned his family to inform them and they visited him in hospital.

30. The clinical reviewer was satisfied that there were no significant delays in the man's diagnosis and this was not affected by his imprisonment. Although he had complained of stomach pains and weight loss for some time, the GP team at the prison carried out appropriate investigations in response to the man's symptoms and referred him quickly after liver function tests showed deterioration. Hospital doctors eventually made a diagnosis only after specialist pathology tests.

The man's clinical care

31. The man's cancer was terminal and no active, curative treatment was possible. On 2 December, the hospital palliative care team reviewed him. His brother went with him to the meeting. There is nothing in his prison medical records to document what was decided at that meeting. However, when the man returned to the prison the next day, he declined any input from the palliative care team. This made it difficult for healthcare staff at the prison to implement a formal end of life care plan.

32. On 4 December, a doctor and the head of healthcare, assessed the man's capacity and noted he was competent and able to make decisions about his care and treatment. The same day, the prison pharmacist spoke to the palliative care nurse at the hospital, who said that they had had difficulty managing the man's pain as his responses to nurses and doctors had not been consistent. As he had declined input from the hospital palliative care team, the team had been unable to implement any care plans.

33. When he got back from hospital on 3 December, Swaleside prescribed a range of painkilling medication, which the hospital had recommended. On 4 December, based on discussion with the man, a doctor prescribed long-acting morphine sulphate tablets 100mg twice daily with morphine 10-20mg as required for breakthrough pain instead of fentanyl, which the hospital had suggested. The clinical reviewer considered that this was a reasonable decision and in accordance with the man's recorded preference. He noted that the doctor had also acted on the advice of a pain specialist nurse, but considered the dose of morphine for breakthrough pain might have been insufficient. This was adjusted when the man reverted to fentanyl patches on 9 December, and the clinical reviewer was satisfied the dose for breakthrough pain was then appropriate. Doctors also prescribed steroids, which are often used in palliative care to improve appetite and give a feeling of wellbeing.

34. Healthcare staff saw the man daily, and took his medication to him. Records show he often refused to take his medication, for various reasons, including

because they made him feel sick or that he was suspicious of the quality. He sometimes complained of neglect. When he refused to take medication, healthcare staff discussed his concerns with him, and sometimes persuaded him to take it, or discussed alternative pain relief.

35. Just before 10.00am on 27 December, a nurse took the man's medication to him. He found the man in bed, unresponsive but breathing. He called for help and a healthcare assistant and another nurse attended. A nurse requested an emergency ambulance and the control room called one at 10.00am. While waiting for the ambulance, the man's oxygen saturation dropped and nurses gave him oxygen. The paramedics arrived at 10.33am and took him to hospital.

36. The man's condition deteriorated and he died in hospital at 9.20am on 29 December. The coroner confirmed the cause of death as pancreatic cancer, which had spread to his liver.

37. The man was reluctant to engage with palliative care specialists and he frequently refused medication, which made it difficult for prison healthcare staff to plan his care. However, the clinical reviewer considered that those involved in the man's care appear to have taken a patient-centred approach and his treatment was equivalent to that he could have expected to receive in the community. We are satisfied that he received an appropriate standard of care at the prison.

The man's location

38. When the man returned from hospital on 3 December, and several times after this, healthcare staff offered him the opportunity to move to the prison's inpatient unit, where nurses were easily accessible. However, he chose to stay on his wing. We are satisfied that staff took his preferences into account and that he received appropriate care on the wing, where healthcare staff saw him every day.

Restraints, security and escorts

39. 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 a 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 judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process, and kept under review as circumstances change. It found that restraining a prisoner receiving life saving treatment for cancer was degrading and would also be likely to be regarded as inhumane, unless it was justified by other relevant considerations.

40. When the man went into hospital on 17 November 2014, the risk assessment authorised the use of double handcuffs. (This is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) There was no healthcare input and it was simply noted 'Cat B prisoner – double cuffed at all times'. Escort officers asked prison managers if they could reduce the level of restraint more then once, including on 21 November when doctors told the man he had cancer, but there is no evidence that anyone reviewed his risk at the time. On 24 November, a manager decided, without any healthcare advice, that the man should continue to be double cuffed. No reasons were given. On 26 November, a manager reviewed the restraints and authorised the use of an escort chain. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.) This was 'on the proviso that he continues not to be a threat to staff or public'.

41. There is no record of any meaningful healthcare input into the risk assessments, commenting on how the man's health and condition affected his risk. Records show that he was often verbally aggressive and non-compliant, but we could find no recent evidence that the man was a risk of harm to himself or others, or of escape. (His conviction, in 2007, was for death by dangerous driving, with a release date of 10 June 2015.) Double handcuffing is usually required for moving category A or category B prisoners in good health and we found no evidence to support the decision to continue double handcuff the man after he went to hospital on 17 November, or that the decision was reviewed appropriately. He was not restrained when he went to hospital on 27 December, but we are not satisfied that the earlier risk assessments properly took into account how his health impacted on his risk, as the High Court judgment requires. We make the following recommendation:

The Governor should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

42. After doctors diagnosed his cancer, he was able to telephone his family and inform them himself and they were able to visit him in hospital. On 3 December, the prison appointed a custodial manager and a senior officer to act as family liaison officers. They agreed with the man's family that they would update them if there was any change in his condition and were in touch at least once a week. The family liaison officers facilitated prison visits for his family during his illness. Members of his family were with him when he died.

43. His funeral was on 23 January 2015. The prison contributed to the cost in line with national guidelines. Apart from communication about compassionate

release (see below) we are satisfied that family liaison arrangements were appropriate.

Compassionate release

44. 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. 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).

45. The prison started an application for compassionate release on 10 December and the man's family were told the required papers were being completed. On 19 December, a hospital doctor said the man had a prognosis of 6 weeks and wrote to the Governor to support early release. A hospital consultant completed the medical section on 23 December. The next day, she discussed the application. Records show that someone told the man that the application had been sent to the Secretary of State for a decision that day. However, this was not the case. The prison probation officer did not support release, because he considered the man had a bad attitude, which would be difficult to manage if he were released. The Governor endorsed this and did not submit the application. No one informed the man or his family. When he went to hospital on 27 December, no one reconsidered the application.

46. Governors have discretion whether to support an application for early release on compassionate grounds and applications will usually require their support. The criteria for compassionate release on medical grounds are that the prisoner is suffering from a terminal illness and death is likely to occur soon; the risk of re-offending is past; that there are adequate arrangements for the prisoner's care and treatment outside prison; and that early release will bring some significant benefit to the prisoner or his family.

47. We are not satisfied that the prison properly considered the man's application against these criteria. In the light of the medical advice, it is difficult to understand how he could still have been considered a risk to the public when he was seriously ill, physically very weak, barely able to walk and with a life expectancy of weeks. In the circumstances, it is difficult to see how his 'bad attitude' would have affected his risk. There might have been a number of other reasons why the man was not suitable for compassionate release, but we do not consider that the reason given for not proceeding with the application was sufficient.

48. Risk is not static and needs to judged and reassessed taking into account any changes in the prisoner's physical condition. We consider that even if the Governor did not support the application on 24 December, she should have

reviewed the decision when his condition deteriorated even further on 27 December. We make the following recommendation:

The Governor should ensure that assessments of risk for the purposes of compassionate release make a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition, that applications are revisited as the prisoner's condition changes and submitted without delay.

RECOMMENDATIONS

1. The Governor should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

2. The Governor should ensure that assessments of risk for the purposes of compassionate release make a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition, that applications are revisited as the prisoner's condition changes and submitted without delay.

ACTION PLAN: The man - HMP Swaleside

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	All governors will be reminded when completing risk assessments for hospital appointments they should be completed taking into account the health of a prisoner and based on the risk he presents at the time. Staff will be given guidance on what actions to take should the offender's health decline prior to the escort commencing and it will form part of the handover briefing for relief staff. This will be reviewed and updated by the security or duty Governor if the offender's condition changes.	Completed Security Governor/Duty Governor with Security and Healthcare advice
2	The Governor should ensure that assessments of risk for the purposes of compassionate release make a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition, that applications are revisited as the prisoner's condition changes and submitted without delay.	Accepted	The Governor will make sure that the risk assessments highlight a distinction between the risks posed by the prisoner when fit and those posed by the same prisoner when suffering from a terminal condition. This should consider the medical and security needs. The application will be revisited when the establishment is notified that a prisoner's condition changes to include a decision log which adequately describes why a decision has been made. It will also describe why other options that have been considered have not been used and include justification for cuffing arrangements, other security considerations and staffing levels.	Completed Security Governor/Duty Governor with Security and Healthcare advice