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 3 December 2014, while in the custody of 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, who died of prostate cancer on 3 December 2014, at Medway Maritime Hospital while in the custody of HMP Swaleside. He was 54 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A doctor reviewed the clinical care the man received at Swaleside. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 2004 and had been at HMP Swaleside since 2006. In July 2012, the man reported abdominal pain which he said he had been suffering from for up to six months. A GP requested some tests but did not perform a rectal examination. In September, the results of a scan indicated that the man had a large mass in his pelvis, indicative of cancer. Doctors informed the man that he had widespread cancer for which only palliative treatment was possible, but did not formally diagnose prostate cancer as the primary site, until January 2013. The man received hormone treatment and radiotherapy to help manage his symptoms and had a number of hospital admissions during the course of his long illness. On 28 November 2014, the man was taken to hospital by emergency ambulance and died five days later.

The investigation found that there was an initial delay of approximately two months in diagnosing the man's cancer, partly due to a failure by a prison doctor to carry out a physical examination. This is a serious concern, but it does not appear that an earlier diagnosis at that point would have altered the outcome for the man. After his diagnosis, I am satisfied that the man received an appropriate standard of care at the prison. However, I do not consider that the use of restraints for hospital visits was always justified by appropriately considered risk assessments. I am also concerned that family liaison could have been more effective.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2015**

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SUMMARY

1. The man was sentenced to life imprisonment on 23 September 2004 and had been at HMP Swaleside since June 2006. The man was a citizen of Uganda and subject to deportation at the end of his sentence.

2. The man first complained of abdominal pain in January 2012. In July, he told a doctor that he had had six months of abdominal discomfort and was worried that it was something serious. The doctor examined him and referred him for blood tests and an ultrasound scan, but did not ask him about weight loss or carry out a rectal examination.

3. On 14 September 2012, the man had an ultrasound scan and, on 18 September, a doctor told him that he had a mass in his pelvis which could be cancer. On 12 October, a CT scan showed extensive cancer, although the primary source was not clear.

4. On 26 October, a nurse referred the man for palliative care to help manage and control his symptoms and pain. The man was in hospital for most of November 2012, and again in January 2013, when doctors diagnosed advanced prostate cancer. Active curative treatment was not possible, but the man began hormone therapy to help slow the progression of the disease.

5. In January 2013, the man's mental health deteriorated. A psychiatrist assessed him on 22 January and found he had fluctuating paranoid thoughts and hallucinations, possibly caused by the cancer spreading to his brain, medication changes or a severe reaction to stress. In April 2013, the Governor decided not to submit an application for compassionate release, principally because of uncertainty about the man's prognosis at the time.

6. From January 2014, the man lived as an inpatient in the prison's healthcare unit. The man continued to receive palliative treatment until 28 November 2014, when he collapsed in his cell. He was taken to hospital and died on 3 December.

7. The clinical reviewer considered that prison GPs missed some opportunities to diagnose the man's condition earlier. After his diagnosis, he received appropriate treatment and some good nursing care. We do not consider that the use of restraints when the man went to hospital for treatment was always justified by fully considered risk assessments. Family liaison should have been more effective. We make three recommendations.

THE INVESTIGATION PROCESS

8. 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.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed three members of staff at Swaleside on 1 February.

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

11. We informed HM Coroner for Kent of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's partner to explain the investigation. The family liaison officer also discussed the investigation with the man's brother. The man's brother wanted the investigation to consider whether the man had received appropriate medical treatment

13. The investigation has assessed the main issues involved in the man'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.

14. The man's family received a copy of the draft report. They did not make any comments. The prison has 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.

HMP SWALESIDE

15. 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 some 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

16. 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. All clinical areas were well equipped and suited to the care and treatment of patients. All prisoners in the unit had care plans but these lacked detailed records of ongoing treatment. 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

17. 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 department was always clean and staff were helpful.

Previous deaths at HMP Swaleside

18. The man's death was the fourth at Swaleside from natural causes since May 2013. In two of the previous investigations, we identified the need for adequate healthcare assessments for prisoners who are seriously unwell, a finding which is repeated in this report.

ISSUES

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

19. The man was serving a life sentence and had been at Swaleside since June 2006. On 3 July 2012, the man told a doctor that he was suffering from abdominal discomfort and was worried that something was not right. The doctor examined his abdomen and told the man that he had no concerns. He planned to review him in four weeks.

20. On 13 July, the man told a nurse that he had all over, lower abdomen pain. A urine test indicated he had an infection and the nurse arranged for him to see a doctor later that day. The man told a doctor that he had been experiencing intermittent lower abdominal pain and bouts of constipation for six months. (There is a note that a nurse saw the man on 6 January, 2012, when he complained of abdominal pain, but there is no record of any outcome or action at the time.) The doctor examined the man's abdomen but did not investigate further, such as through a rectal examination. The doctor concluded there were no 'red flag' symptoms (symptoms which might indicate an underlying serious condition), but did not record what questions he had asked the man. He diagnosed constipation and prescribed a laxative. The doctor referred the man for a routine abdominal ultrasound and asked for further tests of his urine.

21. On 24 July, the same doctor told the man that his urine and blood test results were normal. The doctor again diagnosed constipation and said that an ultrasound scan would rule out any further cause. There is no record that the doctor examined the man at this appointment.

22. Two months later, on 14 September, an ultrasound scan at Medway Maritime Hospital showed a large pelvic mass and enlarged lymph glands, which can be a sign of cancer. On 18 September, a doctor and a nurse informed the man that he had a mass in his pelvis, which could be cancer. The GP referred him urgently under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

23. On 3 October, a colorectal surgeon saw the man and noted he had a large mass filling the whole of the right side of his abdomen and a mass at the prostate. On 12 October, a CT scan confirmed the presence of extensive cancer, although its origin was not clear. It appears that hospital staff informed the man that he had cancer and, on 14 October, the man told a nurse that he knew he had cancer and wanted to be fully informed of all aspects of his treatment and prognosis.

24. The man had a further CT scan and hospital review on 26 October. Although the primary source of the cancer had not yet been established, the nurse referred the man for palliative care to help control his symptoms and offer emotional support. The prison healthcare team contacted the hospital often to get the results of the CT scan, and a complete diagnosis and treatment plan for the man, but got little further information. On 6 November, a haematology consultant admitted the man for further investigation of his condition. The hospital discharged him on 28 November, but there was still no confirmation of the source of his cancer.

25. On 3 December, the man told the nurse that he was frustrated at not having a full diagnosis or treatment plan. On 12 December, a urology registrar saw the man at hospital for further tests. On 21 December, the man declined to attend another hospital appointment as he had had a lot of tests but still did not have a clear diagnosis.

26. On 5 January 2013, the nurse found the man unresponsive in his cell and he was taken to hospital by emergency ambulance. On 11 January, while he was in hospital, a multi-disciplinary team formally diagnosed prostate cancer. The hospital discharged the man on 15 January.

27. The clinical reviewer considered that the doctor missed opportunities for further investigations in July 2012. She noted that a rectal examination is best practice for evaluating abdominal pain and that NICE (National Institute for Health and Care Excellence) clinical guidelines indicate that the GP should not have relied on the absence of visible blood in the man's urine and should have requested a Prostate Specific Antigen (PSA) blood test. The clinical reviewer noted that, although this did not affect the eventual outcome for the man, it contributed to a delay in diagnosis of at least two months and the standard of care fell below that which would normally be expected.

28. The uncertainty of the man's primary diagnosis made it difficult for healthcare staff to answer all his questions about his diagnosis and prognosis. Some of this was unavoidable because of the complexity of investigating his extensive disease, but we are satisfied that prison healthcare staff made considerable efforts to get information from the hospital to keep the man fully informed about his condition. We make the following recommendation:

    The Head of Healthcare should ensure that prison doctors offer rectal examinations for all prisoners with abdominal pain and constipation and follow NICE guidelines for referral for suspected cancer.

The man's medical treatment

29. Active treatment of the man's cancer was not possible because he had extensive, advanced disease at the point of diagnosis. The nurse first referred the man to the hospital palliative care team on 26 October 2012, who saw him on 30 October. The clinical reviewer considered that the nurse referred him on good clinical grounds, before a definitive diagnosis was available, and was satisfied that the palliative care team considered his nutritional needs and pain relief appropriately.

30. The man began hormone therapy for palliative control of his prostate cancer when he was in hospital in January 2013. At this time, hospital staff noticed that his mental health appeared to be deteriorating and asked prison healthcare staff to refer him for a mental health assessment when he was discharged back to Swaleside on 15 January. On 17 January, a member of the prison mental health in reach team assessed the man and a consultant psychiatrist examined him on 22 January. The psychiatrist found he had fluctuating persecutory delusional beliefs and auditory and visual

hallucinations possibly caused by the spread of cancer to his brain, medication changes or a severe reaction to stress.

31. The man's psychiatric symptoms often made assessment of his condition and giving pain relief medications very difficult. He sometimes refused to take medication and thought that staff were trying to poison him. The clinical reviewer noted that this would have made care difficult in any setting, but concluded that the man's access to mental health care and supportive nursing care was better than would have been the case for a patient with similar physical and psychological needs in the community.

32. Healthcare staff contacted the Wisdom Hospice, Rochester, frequently for advice on caring for the man and nurses from the hospice visited the man regularly but he sometimes refused to see them. Nurses appropriately administered long term opiod medications to control his pain. The clinical reviewer was satisfied that, despite the difficulties caused by the man's psychiatric problems, the healthcare team made good attempts to manage his pain and sought appropriate advice from the hospice when necessary.

33. In March 2014, the man had five days of palliative radiotherapy to treat spinal cord compression, which caused weakness in both of his legs. The treatment was partially successful and helped maintain his mobility for a few additional months.

34. On 19 November 2014, the man was taken to hospital after falling out of bed and agreed that he did not want to be resuscitated if his heart or breathing stopped. The next day, he agreed a formal order about this. (The clinical reviewer noted that this does not appear to have been discussed with him before that as a part of his end of life care planning.)

35. When he returned from hospital on 26 November, the man's mobility was very poor. On the afternoon of 28 November, a nurse found the man on the floor by the side of his bed. He was responsive and talking at the time. The nurse called for help and assisted the man into a chair when he became unresponsive. The nurse thought he had suffered a stroke. Healthcare staff called an emergency ambulance, which took the man to hospital. In hospital, the man's condition deteriorated and he died on 3 December. A post-mortem examination confirmed that the man had died of prostate cancer.

36. The man received palliative nursing care at the prison throughout 2013 and 2014. The clinical reviewer noted that during the course of his illness, the man experienced symptoms of pain, rapid weight loss, urinary retention, reduced mobility due to spinal cord compressions and confusion and delusions during the two and a half year course of his illness from diagnosis to death, which overall were managed well. The clinical reviewer identified some areas for improvement which the Head of Healthcare will need to address, but these did not impact significantly on the man's care. The clinical reviewer also identified some areas of clinical good practice and we are satisfied that the man received an appropriate standard of care at the prison.

The man's location

37. At first, after his cancer was suspected, the man wanted to remain on his wing for as long as possible and staff respected his wishes. Nurses visited him frequently in his cell and administered his medication. Healthcare staff offered the man a bed in the healthcare centre more then once, but he declined.

38. On 1 January 2013, the man asked to move to the healthcare centre as he was feeling very unwell and staff moved him. On 4 January, he told a nurse that he missed the company and support of other prisoners on his wing. A doctor agreed that he could go back to his wing that afternoon. The next day, the man was taken to hospital by emergency ambulance and, when he returned to the prison on 15 January, he stayed in the healthcare centre. Subsequently, staff respected the man's wishes to live on the wing as much as possible, but he also spent some time in the healthcare centre when necessary. From January 2014, he lived permanently in the healthcare centre.

39. In November 2014, healthcare staff considered moving the man to a hospice, but there were no beds available at the time. On 19 November 2014, the man went to hospital and, when he came back on 26 November, he was unable to move without help, but there was a mechanical hoist for staff to use. We are satisfied that the man was appropriately located throughout his long illness.

Restraints, security and escorts

40. 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 also found that restraining a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and would also be likely to be regarded as inhumane, unless it was justified by other relevant considerations.

41. The man went to hospital nine times during the course of his two and a half year illness. We have seen risk assessments for a number of these visits. Prison managers always directed the use of restraints, mostly double handcuffs. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health.) The medical section of the assessments did not detail his condition or treatment. They gave no medical objections to the use of restraints rather than commenting on how or whether

the man's medical condition impacted on his risk of escape, as required by the 2007 High Court judgment.

42. On 19 November 2014, when the man was taken by emergency ambulance to hospital the risk assessment concluded that the man should not be restrained because of his terminal condition and his severely restricted mobility. It was agreed that this should be the case for all future escorts. (Although as with the others, the section for medical information on this assessment was not completed.) The prison's Head of Security told the investigator that the prison had recently changed its risk assessment forms in line with national guidance. While we welcome the decision not to restrain the man from 19 November onwards, we are concerned that none of the risk assessments took into account medical opinion about how the man's condition affected his risk of escape. We make the following recommendation:

The Governor should ensure that 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 next of kin

43. The prison did not appoint a family liaison officer until after the man died on 3 December, when an officer took on this role. An operational manager told the investigator that the man had not had any recent contact with his partner and they were unsure if she was still his next of kin. The officer tried to contact the man's partner by telephone to check if she was at home but established that she was away on holiday until the following week. She left a message for the man's partner to contact the prison as soon as possible.

44. On 10 December, the man's partner telephoned the prison and asked if the man had died. The officer confirmed that he had, and offered her condolences. The officer offered to visit the man's partner but she declined. The man's partner gave the man's brother's contact details to the officer and asked that the prison should liaise with him about the man's funeral. The officer arranged with the man's brother in Uganda to repatriate his body there. This was done on 18 February 2015. The prison covered the costs, in line with national guidance.

45. Ideally a member of staff should visit the next of kin in person to inform them of a prisoner's death, but we are satisfied that the prison acted reasonably in the circumstances. However, we consider that some of the delay and confusion about next of kin could have been avoided had the prison spoken to the man about this, as part of his end of life care planning and arranged for someone to liaise with his family throughout his illness. Prison Service Instruction 64/2011 says that an appropriate member of staff should engage with families of prisoners who are either terminally or seriously ill. The operational manager told the investigator that they had been unable to 'track down' the man's partner before he died. However, there is no evidence that anyone discussed contact with his family and next of kin with the man before he died, or that anyone made any attempt to contact his family. The officer was not appointed as the family liaison officer until after the man died. We make the following recommendation:

The Governor should ensure that an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a terminal or serious illness and acts as a point of contact and support.

Compassionate release

46. Prisoners can be released from prison 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 and fulfil other criteria.

47. In April 2013, staff submitted an application for early release on compassionate grounds for the man. The Governor at the time did not support the application and gave uncertainty about the man's prognosis and concerns about his mental health as his reasons. The application did not therefore proceed.

48. There is no record of any further application for early release on compassionate grounds after that in April 2013. However, in the man's circumstances we are satisfied that it was unlikely that he would meet the criteria for compassionate release.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prison doctors offer rectal examinations for all prisoners with abdominal pain and constipation and follow NICE guidelines for referral for suspected cancer.

2. The Governor should ensure that 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.

3. The Governor should ensure that an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a terminal or serious illness and acts as a point of contact and support.

ACTION PLAN: The man – HMP Swaleside

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that prison doctors offer rectal examinations for all prisoners with abdominal pain and constipation and follow NICE guidelines for referral for suspected cancer.	Accepted	All GPs in the practice have been made aware of this requirement and this has been discussed with the members of the clinical effectiveness forum. This ultimately will escalate via the Clinical Governance Board. Lessons learned have been shared amongst all clinicians. A working knowledge of all NICE guidelines is included in the GP development programme; with GPs subject to appraisals and peer review to ensure compliance.	Completed Head of Healthcare
2	The Governor should ensure that 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 prisoner risk assessments for hospital escorts will be undertaken in line with the *Graham* judgement and based on a consideration of the individual's circumstances/current condition and the actual risk that they present at the time of transfer.	Completed Head of Safer Custody
3	The Governor should ensure that an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a terminal or serious illness and acts as a point of contact and support.	Accepted	A Family Liaison Officer (FLO) will be allocated to contact the next of kin of seriously ill prisoners at the earliest opportunity once the seriousness of their condition is diagnosed.	Completed Head of Safer Custody