Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Mallinder a prisoner at HMP Littlehey on 23 April 2016

A report by the Prisons and Probation Ombudsman
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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 David Mallinder died on 23 April 2016 of bronchopneumonia, caused by lung cancer, while a prisoner at HMP Littlehey. He was 69 years old. I offer my condolences to Mr Mallinder's family and friends.

Mr Mallinder had several serious health conditions, including chronic lung disease. I am satisfied that healthcare staff appropriately monitored and treated these in line with national guidelines. Doctors referred him to appropriate specialists twice based on his symptoms, but I am concerned that, although marked urgent, there was a delay in the prison sending him out. It is troubling that this is the fourth time I have identified this failing at Littlehey.

I am also concerned that doctors did not use the NHS two-week urgent cancer referral pathway particularly when a malignancy was suspected in at least one instance. This resulted in a delay in diagnosis. While it is unlikely that an earlier diagnosis would have affected the outcome for Mr Mallinder, in other circumstances such a delay could be crucial.

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 **November 2016**

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Summary

Events

1. On 22 January 2014, Mr David Mallinder was sentenced to five years in prison for sexual offences. He spent a short time at HMP Pentonville before moving to HMP Littlehey on 4 March.

2. Mr Mallinder arrived in prison with an established diagnosis of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) hypertension and arthritis. Mr Mallinder was a heavy cigarette smoker and although staff often advised him to give up, there was no evidence that they offered him a structured smoking cessation programme.

3. In November 2015, Mr Mallinder told a prison GP that he had numbness in his extremities and a loss of appetite. The GP noted he had a cough and was a smoker so referred him for a chest X-ray. The X-ray showed a nodule on his lung and a subsequent CT scan confirmed it was not of concern.

4. On 1 December 2015, Mr Mallinder reported numbness in his hands and feet and that his balance was deteriorating. A prison GP was concerned there may be an underlying malignancy (a term for diseases in which abnormal cells divide without control and can invade nearby tissues, such as cancer) so referred him for an urgent assessment with a neurologist . However, administration staff did not mark the referral letter as urgent and did not send it until a week later.

5. On 4 January 2016, Mr Mallinder said that he had experienced a loss in appetite and was in discomfort. A prison GP made an urgent referral for an assessment by a gastroenterologist. Administration staff did not send this letter until three days later.

6. On 23 February, a hospital gastroenterologist referred Mr Mallinder for a gastroscopy (a procedure to look inside the oesophagus, stomach and small intestine) and a CT scan of his abdomen. The gastroscopy took place on 3 March and showed that he had mild gastritis (inflammation of the stomach lining). The CT scan took place on 15 March and showed that Mr Mallinder had a narrowed artery, which caused pain after eating and weight loss.

7. Mr Mallinder's overall condition continued to deteriorate. A neurologist saw him on 11 April but could not make a diagnosis and planned to arrange a brain scan. Later the same day a prison GP sent him back to hospital with a number of concerning symptoms. Mr Mallinder remained in hospital for investigations. After a CT scan, on 18 April, a consultant told Mr Mallinder that he had lung cancer, though the primary source of the cancer was unknown. Three days later, a lead consultant in palliative care confirmed that Mr Mallinder's cancer was terminal.

8. On 22 April, Mr Mallinder moved from hospital to a hospice for end of life care and he died the following day.

Findings

9. While two prison GPs made appropriate urgent referrals for Mr Mallinder, we are concerned that they did not follow national guidance and use the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. We also found that there were delays in typing and sending the urgent referral letters. As a result, the referral process fell short of expected standards and resulted in a delay in diagnosis.

10. The clinical reviewer also points out that healthcare professionals at the prison did not formally refer Mr Mallinder to a smoking cessation programme, despite his diagnosis of COPD.

Recommendations

- The Head of Healthcare should ensure that prison doctors follow national guidelines on urgent referral for suspected cancer.
- The Head of Healthcare should ensure that all urgent referrals are sent within 24 hours.
- The Head of Healthcare should ensure that prisoners who smoke are offered access to a formal smoking cessation programme, particularly if they are suffering with respiratory diseases.

The Investigation Process

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

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

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

14. We informed HM Coroner for Cambridgeshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Mallinder's friend, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He raised no specific issues or concerns.

16. The investigation has assessed the main issues involved in Mr Mallinder'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.

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

18. Mr Mallinder's friend received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Littlehey

19. HMP Littlehey in Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the population are men convicted of sexual offences.

20. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison's healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.00am to 5.00pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Littlehey was in March 2015. Inspectors noted that an experienced nurse manager and two senior nurses provided effective clinical leadership. Despite chronic problems in recruiting nursing staff, health services had not been affected as regular highly skilled agency staff filled any shortfalls. A small group of regular GPs had significantly improved patient care. Prisoners with lifelong conditions were identified effectively and nurses with additional specialist training provided relevant clinics. Each GP also had an identified specialism, including chronic pain management.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2015, the IMB reported that two healthcare centres, on either side of the prison, allowed easy access to healthcare services for prisoners. However, they were critical that the end of life suite was not used because of a lack of funding for its operation.

Previous deaths at HMP Littlehey

23. Mr Mallinder was the tenth prisoner to die of natural causes since April 2014. Subsequently, there have been two more natural cause deaths. We have raised the issue of processing urgent referrals before.

Findings

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

24. On 22 January 2014, Mr Mallinder was sentenced to five years in prison for sexual offences. He spent time at HMP Pentonville and had been at HMP Littlehey since 4 March 2014.

25. He arrived in prison with an established diagnosis of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), arthritis and high blood pressure. Mr Mallinder was a heavy cigarette smoker, and continued to be into his final illness despite the advice of healthcare staff. Throughout his time at Littlehey, healthcare staff often told him to quit smoking but there was no evidence that he was invited to attend a formal smoking cessation programme.

26. Healthcare staff saw Mr Mallinder regularly in relation to his health conditions and doctors prescribed appropriate medication.

27. On 6 November 2015, Mr Mallinder complained of numbness in his extremities and loss of appetite. Because Mr Mallinder was a heavy smoker with a cough prison GP referred him for a chest X-ray which he had on 12 November. The results were compatible with his known COPD and also revealed a possible nodule in his chest. A CT scan to check the nodule was undertaken on 20 November and showed he had a single enlarged mediastinal lymph node (a gland that is located in the chest between the sternum and spinal column) which gave no cause for concern.

28. On 1 December, Mr Mallinder told prison GP that the numbness in his hands and feet and his balance were worsening. The GP noted that Mr Mallinder had undergone a chest X-ray and CT scan in November. He suspected an underlying malignancy and made an urgent referral to a neurologist at hospital.

29. A healthcare administrator typed the prison GP's referral letter on 7 December and sent it on 9 December but did not mark it as urgent. As a result, the hospital placed Mr Mallinder on the routine referral waiting list.

30. On 4 January 2016, a prison GP saw Mr Mallinder, who had experienced a loss in appetite and had some abdominal discomfort. She noted that in addition to his various other symptoms, he was losing weight, so she made an urgent referral to a gastroenterologist. A healthcare administrator did not type and fax the letter until 7 January.

31. The hospital originally made an appointment with the gastroenterologist for 20 January. However, they did not tell Mr Mallinder he should fast before the appointment, so they had to rearrange the appointment for 23 February.

32. On 2 February, another prison GP saw Mr Mallinder because he was retching. The GP noted that Mr Mallinder had undergone a chest X-ray and CT scan in November and was waiting to see the gastroenterologist.

33. On 23 February, a gastroenterologist examined Mr Mallinder and referred him for a gastroscopy (a procedure to look inside the oesophagus, stomach and small intestine) and a CT scan of his abdomen.

34. Mr Mallinder's gastroscopy took place on 3 March and showed that he had mild gastritis (inflammation of the stomach lining). He underwent a CT scan of his abdomen on 15 March which revealed a narrowed artery, which caused pain after eating and weight loss. A consultant gastroenterologist wrote to the prison, on 24 March, and said that she wanted to see Mr Mallinder to discuss his symptoms in the light of the results. However, Mr Mallinder was admitted to hospital before the appointment could be arranged.

35. A nurse saw Mr Mallinder on 23 and 27 March, after prison staff and prisoners raised concerns about his deteriorating condition. He was not looking after himself and she noted that he was waiting on an urgent social care assessment. On 30 March, the assessment recommended a care package to assist Mr Mallinder with his personal care, and this started on 4 April.

36. Mr Mallinder's overall condition continued to deteriorate including being very unsteady, weak and dizzy and not eating. On 11 April, a neurologist reviewed him at hospital. The neurologist was unable to diagnose Mr Mallinder and wanted him to have a brain scan and an electromyography (EMG – a test used to help detect neuromuscular abnormalities). He returned to Littlehey with a plan to have these tests at a later date.

37. Later the same day, a prison GP saw Mr Mallinder. She sent him back to hospital as an emergency, due to his weight loss, dysphagia (difficulty swallowing) and ataxia (loss of control of bodily movements). He saw the neurological team who diagnosed paraneoplastic syndrome (a set of signs and symptoms that is the consequence of cancer). Due to the continuing deterioration in his condition, they did not consider him to be fit for a biopsy (the removal of a small sample of tissue for examination).

38. Mr Mallinder remained in hospital for further investigations. On 18 April, after a CT scan of his chest, a consultant told him that he had lung cancer, although the primary source of the cancer was unknown. Three days later, a lead consultant in palliative care confirmed that Mr Mallinder's cancer was terminal.

39. The clinical reviewer said that prison GPs appropriately and urgently referred Mr Mallinder to neurology and gastroenterology based on his symptoms. However, they did not make either referral in line with The National Institute for Health and Care Excellence (NICE) guidelines to use the NHS suspected cancer pathway (which which requires patients with suspected cancer to be seen by a specialist within two weeks). Also, despite both referrals being urgent, there were delays in the prison faxing the referral letters to the relevant departments. These delays meant that a specialist did not see Mr Mallinder early enough and there was a delay in diagnosis, although the clinical reviewer said this did not affect the eventual outcome for Mr Mallinder. We note that Littlehey has a clear healthcare protocol that states urgent referrals (which are dictated by the GPs) should be written up and faxed to the hospital within 24 hours, yet this is clearly not happening. This is the fourth time we have raised this issue with Littlehey in recent investigations and it needs to be addressed.

40. Additionally, while the healthcare team correctly identified and monitored Mr Mallinder's long term conditions, as he was a smoker with a respiratory condition, they should have formally invited him to a structured smoking cessation programme. We make the following recommendations:

The Head of Healthcare should ensure that prison GPs follow national guidelines on urgent referrals for suspected cancer.

The Head of Healthcare should ensure that all urgent referrals are sent within 24 hours.

The Head of Healthcare should ensure that prisoners are offered access to a formal smoking cessation programme, particularly if suffering with respiratory diseases.

Mr Mallinder's clinical care

41. On 18 April, the oncology team at the hospital discussed Mr Mallinder's deteriorating condition, and agreed to treat him palliatively.

42. Mr Mallinder moved from hospital to a hospice on 22 April for end of life care. He died at 11.50am the next day.

43. A post-mortem concluded that Mr Mallinder died from bronchopneumonia and a lung abscess, caused by small cell lung cancer.

44. All Mr Mallinder's treatment after his diagnosis was administered in hospital, which is outside the remit of this investigation.

Mr Mallinder's location

45. Mr Mallinder lived in a unit specifically for older men at Littlehey. As he had limited mobility, the prison allocated him a ground floor cell where he remained until admitted to hospital.

46. As his condition deteriorated, Mr Mallinder received a social care assessment, which confirmed his location was suitable, although he required some assistance with personal care which was provided. We are satisfied that he was appropriately located during his time at Littlehey.

Restraints, security and escorts

47. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

48. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

49. Due to his medical condition, a senior prison manager decided that officers should not restrain Mr Mallinder at all during his time in hospital or later when he moved to the hospice for end of life care. We are pleased that the prison took a humane approach, which appropriately considered Mr Mallinder's health and how it impacted on any risk he presented.

Liaison with Mr Mallinder's family

50. When Mr Mallinder was admitted to hospital on 11 April, a custodial manager contacted Mr Mallinder's friend, his nominated next of kin, to inform him.

51. The following day, the prison appointed a custodial manager as the family liaison officer. The custodial manager contacted Mr Mallinder's next of kin to introduce himself and explain his role. He kept Mr Mallinder's friend updated about his condition and when he moved to the hospice for end of life care. Mr Mallinder's next of kin asked the custodial manager to telephone him when Mr Mallinder died.

52. After Mr Mallinder's death, the custodial manager telephoned his friend to inform him and offer condolences and support. Mr Mallinder's funeral was on 19 May. The prison arranged and paid for this in line with national instructions.

53. We are satisfied that there was good liaison between the prison and Mr Mallinder's next of kin.

Compassionate release

54. Prisoners can be released from custody 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.

55. Mr Mallinder's terminal cancer was diagnosed on 21 April and he died two days later. There was insufficient time for the prison to complete and submit an application for compassionate release.

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