

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Elcombe a prisoner at HMP Usk on 1 May 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Elcombe died on 1 May 2016 of kidney cancer while a prisoner at HMP Usk. He was 65 years old. I offer my condolences to Mr Elcombe's family and friends.

I consider that, initially, Mr Elcombe generally received a good standard of clinical care at HMP Usk, but as his condition deteriorated his pain management fell short of that he could have expected to receive in the community. While the prison made attempts to arrange a transfer to a prison where he could receive 24-hour nursing care and therefore pain relief at night, Mr Elcombe suffered unnecessarily because a transfer could not be arranged and because clinicians could not agree on alternative pain relief.

I am also not satisfied that prison managers authorising the use of restraints always properly considered Mr Elcombe's health and how this might impact on his risk of escape, an issue I have raised in relation to previous deaths at Usk.

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

December 2016

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Summary

Events

1. Mr Richard Elcombe was sentenced to life imprisonment for sexual offences on 13 October 1989. He spent time at a number of prisons before being moved to HMP Usk on 12 August 2014.
2. On 1 June 2015, Mr Elcombe collapsed and was admitted to hospital. A chest X-ray identified possible lesions in his left lung, but when repeated, on 9 June, the X-ray did not show any abnormalities.
3. Clinicians admitted Mr Elcombe to hospital again on 3 August with chest pains and shortness of breath. Further X-rays indicated lesions in his left lung and a CT scan on 7 August revealed cancerous tumours in Mr Elcombe's left lung and right kidney.
4. On 10 August, after his return to prison, healthcare staff began exploring options for a transfer to a prison where Mr Elcombe could access 24-hour medical care. In August, Usk arranged a transfer to Parc, which subsequently would not accept Mr Elcombe. In the following months, Mr Elcombe attended hospital regularly for treatment, returning to Usk on each occasion.
5. The prison made further attempts to transfer Mr Elcombe in November, when his health began deteriorating. Despite their efforts, a transfer could not be arranged and Mr Elcombe remained at Usk.
6. Initially, clinicians managed Mr Elcombe's pain with codeine (pain relief). However, as his condition deteriorated, he required stronger pain relief, which healthcare at Usk could not provide. He was admitted to hospital on 5 and 18 February 2016 with severe pain but, on both occasions, when subsequently discharged, Mr Elcombe was not provided with appropriate pain relief due to the prison's restrictions and healthcare regime.
7. Mr Elcombe continued suffering significant pain and was re-admitted to hospital on 22 February. He remained in hospital for end of life care and died on 1 May 2016 of metastatic renal cell carcinoma.

Findings

8. The clinical reviewer considered that the general standard of care that Mr Elcombe received at Usk was good, but noted concerns with the management of his pain in the later stages of treatment.
9. Transfer to a prison with 24-hour medical care would have enabled Mr Elcombe to access appropriate pain relief medication. Prison staff made a number of attempts to transfer Mr Elcombe to other prisons, but these attempts were ultimately unsuccessful. We are concerned that the failure to transfer Mr Elcombe prevented him from accessing healthcare services and appropriate pain relief, equivalent to that he could have expected to receive in the community. We are also concerned that prison healthcare staff did not consider alternative options to ensure that Mr Elcombe had appropriate pain relief.

10. On the last occasion Mr Elcombe went to hospital, prison managers approved the use of restraints, despite not restraining him for another hospital admission earlier that month due to his serious condition. While prison managers quickly decided to remove the restraints, we are concerned that Mr Elcombe's health had deteriorated significantly in February and that the initial decision to restrain him was inappropriate. We are not satisfied that there was sufficient healthcare input into the risk assessment process for managers to make a fully informed decision.

Recommendations

- The Governor and the Head of Healthcare should ensure that seriously ill prisoners receive appropriate pain relief at all times.
- The National Offender Management Service should ensure that there is an effective mechanism for transferring prisoners with particular health care needs to appropriate prisons and that prisons are instructed about how to make and pursue such requests expeditiously.
- The Governor and Head of Healthcare 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.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Usk informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Elcombe's prison and medical records.
13. Healthcare Inspectorate Wales (HIW) reviewed Mr Elcombe's clinical care at the prison. The investigator and the HIW reviewer interviewed six members of staff at Usk on 7 June 2016.
14. We informed HM Coroner for Wales Gwent 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 Elcombe's sister to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not raise any specific concerns.
16. The investigation has assessed the main issues involved in Mr Elcombe'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 pointed out some factual inaccuracies and this report has been amended accordingly.
18. Mr Elcombe's sister received a copy of the initial report. She pointed out a factual inaccuracy and/or omissions. This report has been amended accordingly.

Background Information

HMP Usk

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

HM Inspectorate of Prisons

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

Independent Monitoring Board

21. 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 June 2016, the IMB reported that healthcare at the prison was responding well to an ageing prison demographic. Day care facilities were available at Usk, but there are no beds for in-patients. The IMB also reported that when a prisoner is admitted to hospital, providing a constant escort can seriously affect regimes at the prison, resulting in increased time in cells.

Previous deaths at HMP Usk

22. Mr Elcombe was the third prisoner to die of natural causes at HMP Usk since January 2015. The circumstances of Mr Elcombe's death were similar to the preceding death at the prison, where we also raised concerns the use of restraints.

Findings

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

23. On 13 October 1989, Mr Richard Elcombe was sentenced to life imprisonment for sexual offences. He spent time at a number of prisons before arriving at HMP Usk on 12 August 2014. He suffered ongoing pain in his back from an old injury, which doctors treated with cortisone and pain relief medications.
24. On 1 June 2015, Mr Elcombe's cell mate told a healthcare assistant, that Mr Elcombe had collapsed after feeling unwell. The healthcare assistant and a prison GP reviewed Mr Elcombe in his cell and an ECG (a test to check the heart's rhythm and electrical activity) gave abnormal results. In consultation with the on-call cardiologist, the doctor decided to send Mr Elcombe to Nevill Hall Hospital, Abergavenny. The hospital admitted Mr Elcombe and a chest X-ray indicated possible lesions in his left lung. The X-ray was repeated on 9 June but did not show any abnormalities. As a consequence, clinicians focused on investigating suspected problems with Mr Elcombe's heart.
25. On 3 August, Mr Elcombe complained of pain in the left side of his chest and shortness of breath while sitting down. A prison GP performed an ECG and decided to send him to hospital. The hospital carried out further chest X-rays, which indicated lesions in his left lung. Hospital staff were concerned that the lesions were cancerous, so they made an urgent referral under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
26. A high resolution CT scan, on 7 August, revealed cancerous tumours in Mr Elcombe's left lung and right kidney. Hospital doctors discussed the diagnosis with Mr Elcombe that afternoon and he returned to prison on 10 August. The Head of Healthcare and a prison GP discussed the diagnosis, plans for treatment and likely prognosis with Mr Elcombe later that day.
27. Prison doctors appropriately sent Mr Elcombe to hospital for investigations. We do not know why the chest X-ray on 9 June did not find any abnormalities but, in light of the negative result, the clinical reviewer noted it was reasonable for clinicians to focus on investigating issues with Mr Elcombe's heart. The clinical reviewer also noted that, due to the significant spread of cancer, the resulting delay in diagnosis did not affect the outcome for Mr Elcombe.

Mr Elcombe's clinical care

28. Hospital doctors began treating Mr Elcombe with radiotherapy on 15 September, which continued for many months. He often suffered infections and poor health as a side effect of the radiotherapy. When required, healthcare staff sent him to hospital for treatment.
29. Prison doctors initially treated Mr Elcombe's pain with codeine, a pain relief medication. Records show that on 18 September, as his pain worsened, doctors prescribed him gabapentin (a medium strength pain reliever) in addition to a

stronger dose of codeine. Clinicians managed Mr Elcombe's pain and symptoms appropriately in the period from diagnosis to January 2016.

30. On 23 November, a nurse discussed Mr Elcombe's care needs with the Head of Healthcare. They agreed to commence palliative care plans after his next oncology appointment on 30 November.
31. Over the next 10 weeks, healthcare staff saw Mr Elcombe regularly as his condition deteriorated.
32. On 5 February 2016, after suffering severe chest pains, hospital doctors recommended that prison doctors prescribe Mr Elcombe stronger opioid pain relief, in addition to his codeine and gabapentin. However, due to the prison's policy on controlled drugs and there being no healthcare staff on duty at night, healthcare staff did not change Mr Elcombe's pain relief prescription.
33. Mr Elcombe's pain worsened and, on the morning of 18 February, healthcare staff sent him to hospital, as he had severe chest pains. The hospital treated his pain with morphine and discharged him the next day. They prescribed him a stronger dose of gabapentin but this did not provide the pain relief he needed.
34. On 22 February, Mr Elcombe said that his level of pain had not decreased so healthcare staff sent him back to hospital. The hospital admitted him and agreed that the prison could no longer care for Mr Elcombe adequately so he should remain in hospital until arrangements for his end of life care were made.
35. On 29 February, the Head of Healthcare visited Mr Elcombe to discuss end of life care. Mr Elcombe said that he wished to remain at Usk and the prison developed plans for a package of care to meet his wishes. However, Mr Elcombe's condition did not improve and doctors decided he should remain in hospital.
36. Mr Elcombe's health gradually declined and he died in hospital at 10.15pm on 1 May. A post-mortem examination showed that Mr Elcombe died of metastatic renal cell cancer (cancer of the kidney that has spread to other parts of the body).
37. We agree with the clinical reviewer that, until February 2016, Usk met Mr Elcombe's healthcare needs. However, as his condition deteriorated and his need for stronger pain relief medication increased, we share the clinical reviewer's concerns that this was not managed effectively.
38. Under Prison Service rules, controlled drugs must be given to prisoners under supervision. As Usk does not provide healthcare services in the evening or at weekends, they could not supply Mr Elcombe with his prescribed pain relief medications at these times. Records show that healthcare staff contacted hospital clinicians, cancer specialists and palliative care nurses but could not identify suitable alternatives for management of his pain. Healthcare staff told us that prison officers cannot administer medications to prisoners because their employment contracts do not cover those services. Since it was not possible for prison officers to give Mr Elcombe stronger pain relief medication during out of hours periods, healthcare staff focused on arranging a transfer to another prison where his pain could be appropriately managed. However, despite their efforts, a

transfer could not be arranged and Mr Elcombe remained at Usk and continued to suffer increasing pain without appropriate access to pain relief.

39. While we accept that the prison made efforts to transfer Mr Elcombe to a prison with 24-hour medical care, we are concerned that it was not possible to achieve other options for his pain relief. The clinical reviewer pointed out that using stronger opiate medication given twice daily in tablet form or by applying a patch to the skin to release the medication slowly over twenty four hours were both possibilities, negating the need for anyone to administer medication out of hours. However, a prison GP told us this was not possible because of restrictions at the prison on opiate medication. He told us they went to the highest clinical lead to try and make arrangements to provide appropriate pain relief but it could not be achieved, and clinicians at Usk pinned their hopes on a prison transfer.
40. Clearly, prison policies on the management of controlled medication are important in the effort to control the trading and illicit use of drugs. However, it is not acceptable that Mr Elcombe remained in considerable pain and clinicians were frustrated at not being able to relieve it. We consider that both prison managers and senior clinicians should have discussed options and found a way to achieve appropriate pain relief for Mr Elcombe. We agree with the clinical reviewer that, in the later stages of Mr Elcombe's treatment, pain management did not meet the standard of care he could have expected to receive in the community. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that seriously ill prisoners receive appropriate pain relief at all times.

Mr Elcombe's location

41. Mr Elcombe lived on a normal accommodation wing at Usk and shared a cell with another prisoner who assisted him with daily activities as his condition declined. His cell was suitable for his needs until it became evident that he was seriously ill and the prison attempted to transfer him to another establishment with 24-hour healthcare.
42. On 10 August, the Head of Healthcare discussed the cancer diagnosis with Mr Elcombe and explained that, once his condition deteriorated, he would need 24-hour medical care. Mr Elcombe agreed and she contacted the Head of Healthcare at HMP Parc later that day.
43. Parc initially agreed to the transfer but then told Usk that they had accepted the transfer in error. Usk referred Mr Elcombe's transfer to the National Offender Management Service for review. An Operations Manager concluded that Mr Elcombe could receive appropriate care at Usk and told a nurse, on 12 August, that Mr Elcombe's transfer should wait until more information on plans for his treatment was available. Records show that after attempting to transfer Mr Elcombe in August, no further attempts to arrange a transfer were made until he deteriorated further in November 2015.
44. On 23 November, the prison tried to arrange a transfer to HMP Lewes, but the prison did not have any space.

45. On 26 November, the Head of Healthcare wrote to Mr Elcombe's oncology consultant, asking for information on his treatment and prognosis in order to arrange his transfer to another prison. Mr Elcombe gave his consent to the disclosure of this information, but the report was not received until almost two months later. During this period, Mr Elcombe remained at Usk as his condition deteriorated.
46. The prison made many attempts to arrange Mr Elcombe's transfer to other prisons. Nursing staff and prison managers contacted HMP Highdown, HMP Lewes and HMP Parc a number of times, but could not secure a transfer. Records show that prison managers rejected the transfer for operational reasons including Mr Elcombe's vulnerable prisoner status and lack of family connections.
47. On 22 February, Mr Elcombe's condition significantly deteriorated and he returned to hospital, where he remained until he died.
48. Earlier transfer to a prison with 24-hour medical care would have enabled Mr Elcombe to receive appropriate treatment for management of his pain in the later stages of his illness. We are concerned that the failure to arrange a transfer prevented Mr Elcombe from accessing healthcare services, equivalent to that he could have expected to receive in the community.
49. It is clear that staff at Usk tried many times to arrange a transfer. However, it is apparent from reviewing the records and speaking to the staff involved that the focus was not on his pain management as a requirement for 24-hour healthcare, which should have been the case. We found that one of the reasons given for requesting a transfer was for Mr Elcombe to be near to his family, when this was never an issue and no suggestion that Mr Elcombe requested this. Mr Elcombe's vulnerable prisoner status proved to be a barrier, but requests did not make clear that he would not be on normal location, but in healthcare. We make the following recommendation:

The National Offender Management Service should ensure that there is an effective mechanism for transferring prisoners with particular health care needs to appropriate prisons and that prisons are instructed about how to make and pursue such requests expeditiously.

Restraints, security and escorts

50. 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.

51. When Mr Elcombe went to hospital on 5 February, the medical section of the risk assessment noted that he should not be restrained, and a manager approved this. The prison was unable to provide us with the records for his admission on 18 February. However, an operational manager told us that the escorting officers carried out hourly checks of equipment to account for their whereabouts, which may suggest that Mr Elcombe was restrained at this time.
52. The risk assessment for Mr Elcombe's admission to hospital at 5.00pm on 22 February did not raise medical objections to the use of restraints and noted that Mr Elcombe presented a low risk to the public. A Supervising Officer authorised officers to restrain Mr Elcombe with handcuffs. Later that evening, a custodial manager reviewed the risk assessment and authorised officers to remove the restraints. Mr Elcombe was not restrained again.
53. Prison managers decided not to restrain Mr Elcombe for his admission to hospital on 5 February. However, he was restrained when admitted back to hospital on 22 February. We are pleased that a senior manager reviewed the decision on 22 February and decided to remove the restraints the same day. Mr Elcombe was seriously ill and in considerable pain, yet the medical section of the risk assessment for 22 February gives no information and did not object to the use of restraints. We are concerned that prison managers made the decision to restrain without sufficient information on how Mr Elcombe's condition impacted on his risk of escape. We make the following recommendation:

The Governor and Head of Healthcare 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 Mr Elcombe's family

54. Mr Elcombe's nominated next of kin was his sister. The prison kept her informed about his condition and treatment regularly throughout his illness. As his condition deteriorated in hospital, on 18 March, the prison appointed an officer as the family liaison officer. She contacted Mr Elcombe's sister the same day to tell her that he was more unwell. Mr Elcombe's sister visited him at hospital two days later.
55. On 2 April, Mr Elcombe's sister said that she preferred to be informed of his death by telephone. Once his condition deteriorated, the prison arranged for Mr Elcombe to speak to his sister on the telephone.
56. Hospital staff contacted Mr Elcombe's sister on the evening he died to break the news of his death. The following day, the officer contacted Mr Elcombe's sister to offer condolences and support. During their conversation, the officer offered to visit her in person, but Mr Elcombe's sister declined the offer because she did not want to inconvenience them.
57. Mr Elcombe's funeral was on 19 May. The prison arranged and paid for the funeral in line with national policy.

Compassionate release

58. 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.
59. On 29 February, the Head of Healthcare visited Mr Elcombe to discuss his wishes for end of life care. Mr Elcombe said that, given his close connection to staff at the prison, he wanted to spend his remaining time at Usk and did not want to apply for compassionate release.
60. At a meeting on 15 March, clinicians and prison managers concluded that Mr Elcombe required 24-hour care, and given that he did not have family willing to care for him, it would be inappropriate to pursue compassionate release. Instead, they agreed to develop a package of care to meet his wishes for end of life care at Usk in keeping with his wishes. At a meeting on 1 April, hospital doctors determined that Mr Elcombe lacked the mental capacity to make decisions on his treatment needs. They noted he now needed 24-hour access to qualified nursing care to monitor swallowing, medication, continence and non-verbal signs of pain and agreed that he should remain in hospital for end of life care.
61. We note that Mr Elcombe expressed a wish to remain in prison for his end of life care, but this was not possible given his nursing needs. We are satisfied that the prison appropriately considered compassionate release and did not progress this for the right reasons.

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