Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of a man, a prisoner at HMP Elmley, on 22 February 2015

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 such as this, 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.

The man died of liver disease on 22 February 2015, while a prisoner at HMP Elmley. He was 43 years old. I offer my condolences to his family and friends.

The investigation found evidence of clear and concise care plans, and good liaison with the hospital and palliative care team. Although there was a delay with the man's diagnosis, when blood test results were not followed up quickly, the clinical reviewer considered that an earlier diagnosis would not have prevented his death. Overall, he received a good standard of care at the prison. However, I consider that the prison should have appointed a family liaison officer when it became clear that his illness was terminal. I am also not satisfied that managers always fully considered his health and mobility when authorising the use of restraints for hospital visits.

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 **November 2015**

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Summary

Events

1. The man had been at HMP Elmley since September 2011. He had a history of drug and alcohol addiction, and in 2006 was diagnosed with hepatitis C. He had long-standing leg ulcers and had been on a high dose of opiate-based medication for many years for chronic pain.

2. In October 2013, hospital doctors diagnosed the man with deep vein thrombosis (DVT) and blood tests at the hospital indicated some abnormalities in liver function. No follow up action was planned at the time, but healthcare staff continued to take blood tests to monitor his leg condition. In March 2014, a blood test showed abnormal liver function. A GP requested repeated blood tests, but there was a delay in obtaining these, partly because he refused to attend appointments. In May 2014, a doctor referred him to hospital after another blood test showed abnormal liver function and clotting profiles. In hospital, doctors diagnosed him with serious liver disease.

1. In October 2014, hospital doctors decided that the man was not suitable for a liver transplant. When he returned to the prison, a doctor recorded that treatment for his liver condition had reached a palliative stage. Healthcare staff created care plans and suggested they should care for him as an inpatient in the prison's healthcare centre, but he wanted to stay on his wing. Nurses visited him regularly to give him medication and monitor him. An application for compassionate release was rejected, as he did not have a clear prognosis of less than three months.

2. On 16 January 2015, the man had severe abdominal pain and was taken to hospital by emergency ambulance. He remained in hospital and his condition deteriorated. He died in hospital on 22 February 2015.

Findings

3. Healthcare staff developed clear and concise care plans for the man and there was effective liaison with the hospital and palliative care team. The clinical reviewer noted that, with hindsight, some earlier blood tests could have been more actively followed up. This might have led to an earlier diagnosis of liver failure, but would not have prevented his death. The clinical reviewer was satisfied that the standard of his care at the prison was equivalent to that he could have expected to receive in the community.

4. The prison did not appoint a family liaison officer until shortly before the man died. This meant that he and his family were not fully supported after his diagnosis. We are also concerned that managers at Elmley authorised the use of restraints for a hospital visit, without full information about his health and mobility and how this affected his risk.

Recommendations

- The Head of Healthcare should ensure that abnormal blood test results are appropriately followed up, especially where a prisoner has a diagnosis or history of hepatitis C.
- The Governor and Health 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 Governor should ensure that a member of staff is appointed to engage with families of terminally or seriously ill prisoners and inform them at once if they are admitted to hospital.

The Investigation Process

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

6. The investigator obtained and reviewed copies of relevant extracts from the man's prison and medical records.

7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

8. We informed HM Coroner for Mid-Kent of the investigation, who sent the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted the man's partner to explain the investigation and to ask if she had any matters she wanted the investigation to take into account. She asked for the following to be considered:

    - Whether his physical symptoms were identified and responded to in an appropriate and timely manner.
    - Whether he continued to receive the medication he had been prescribed in the community after he arrived at prison, and whether there was appropriate continuity of care.
    - She considered that there had been insufficient communication from the prison about his health before his death.
    - Whether the prison had followed the correct procedure for compassionate release was followed by the prison.

10. 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.

11. The man's partner received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

12. The draft report was shared with the prison service. There were no factual accuracies and the action plan has been annexed to this report.

Background Information

HMP Elmley

13. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services at Elmley. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

14. The most recent inspection of Elmley was in June 2014. The Inspectorate reported that the overall quality of health services was reasonably good, but there was a high rate of non-attendance at primary care clinics. Initial and secondary screenings were effective, with appropriate focus on drug, alcohol and mental health issues. There was good access to therapeutic services in the inpatient unit.

Independent Monitoring Board

15. 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 October 2014, the IMB found that long term chronic disease management was well monitored and patients with complex cases were seen for regular reviews.

Previous deaths at HMP Elmley

18. The man was the fifth person to die of natural causes at Elmley since January 2014. We have raised the issues of following up blood tests and the use of restraints before.

Findings

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

19. At an initial reception screen on 11 September 2013, a nurse noted the man had painful ulceration on both legs for which he received antibiotics and pain relief. He said he was not dependent on alcohol. He declined hepatitis C screening. The nurse recorded that he appeared lethargic and drowsy and might not have given an accurate account of his medical history. A prison GP assessed him and re-prescribed antibiotics and pain relief for his ulcerated legs. The GP admitted him to the prison's inpatient unit for a physical health assessment. He noted the man had been on high levels of opiate medication for some years and he was referred to the chronic pain team to check and manage his pain relief medication.

20. A nurse created a care plan to monitor the man's ulcerated legs and gave him crutches, as his mobility was limited. On 16 September, a prison GP reviewed him and noted that information from his community GP indicated he had been diagnosed with hepatitis C in 2006. The GP also recorded that he had a history of bilateral deep vein thrombosis (DVT) and drug use. He said he had not taken drugs for over seven years and did not want to be referred to the substance misuse team.

21. On 29 October, the man attended an outpatient appointment at hospital for tests on his ulcerated legs. Doctors diagnosed a deep vein thrombosis (DVT). His discharge summary showed that blood tests in hospital had revealed abnormal liver function. When he returned to prison a GP prescribed anti-coagulant injections. There is no record of any follow up of the blood results.

22. Prison healthcare staff tested the man's blood regularly to monitor his leg condition. There were sometimes delays in getting blood samples as he often declined to attend healthcare appointments and had poor veins (which required specialist hospital equipment). On 3 March 2014, blood test results indicated abnormal liver function and a GP appointment was made for the next day. On 4 March, a GP reviewed him and discussed his medication, but there is no record that he discussed the blood test results. On 6 March, a GP noted there was a need to repeat the blood tests. He refused to attend some healthcare appointments in March and April and there is no record that the repeat tests were carried out.

23. On 25 March, a nurse referred the man to a GP, as he appeared jaundiced. On 3 April, a GP examined him and diagnosed fluid retention. He prescribed a diuretic to remove the excess fluid. There is no record that the GP considered his blood tests, which indicated abnormal liver function, or his history of hepatitis C.

24. On 1 May, a GP arranged an immediate blood test after a nurse noticed that the man still appeared jaundiced. The results suggested he might have liver failure. The GP referred him to hospital. The hospital admitted him and tests showed a shortage of both red and white blood cells. His liver was not functioning normally and his blood clotting profiles were abnormal. Doctors diagnosed probable chronic liver disease and gallstones.

25. On 7 May, the man returned to the prison. The next day, the GP explained the diagnosis to him.

26. We are satisfied that the man was appropriately diagnosed with liver failure. The clinical reviewer noted that blood tests in September 2013 and March 2014, showed abnormalities of liver function and that it would have been best practice to have followed these up with further investigations, particularly in view of his previous diagnosis of hepatitis C, which can lead to liver disease. However, while earlier investigations might have led to his liver disease being diagnosed sooner, this would not have prevented his death. We make the following recommendation:

The Head of Healthcare should ensure that abnormal blood test results are appropriately followed up, especially where a prisoner has a diagnosis or history of hepatitis C.

The man's clinical care

27. On 7 May, after explaining the man's diagnosis to him, a GP prescribed lactulose (to prevent the build up of toxins in the blood), spironolactone (a diuretic), and zomorph (as pain relief). A nurse created a care plan to manage his medical condition and monitor his mental health. On 19 May, a GP examined him and recorded he had ascites (a condition, often associated with liver disease, where fluid collects in the abdomen). He referred him to hospital for further treatment.

28. Over the next six months healthcare staff regularly assessed the man, and reviewed and adjusted his medication when required. He went to hospital seven times for treatment. A test in June 2014, confirmed he was hepatitis C positive.

29. On 24 October, the man was assessed at hospital for a possible liver transplant. On 31 October, doctors told him that he was not clinically suitable for a transplant because of his history of non-compliance with medical advice, concerns about addiction and his poor health. A hospital doctor told him that he had a thirty percent chance of dying within the next three months. He returned to the prison that day.

30. On 4 November, a GP discussed the man's prognosis with him and offered support. Healthcare staff referred him to the hospital's palliative care team. Palliative nurses visited him and gave advice on managing his symptoms. Healthcare staff reviewed and updated his care plan and medication as his condition deteriorated. His mobility was limited and he had crutches and a wheelchair to help him get about.

31. In November and December, the man went to hospital twice when his condition deteriorated and to another hospital for an appointment. Subsequently, he twice rejected a doctor's advice that he should go to hospital.

32. On 16 January 2015, the man was taken to hospital by emergency ambulance after complaining of abdominal pain. Prison healthcare staff kept in contact with the hospital for updates on his condition. On 13 February, a hospital palliative care nurse saw him and noted that he had he had only days to weeks left to live. He died in hospital on 22 February. A post-mortem examination reported the cause of death as end stage cirrhosis (liver disease).

33. We are satisfied that after the man's diagnosis his care at Elmley was equivalent to that he could have expected to receive in the community. He had appropriate care plans and prison healthcare staff worked effectively with hospital staff and palliative care nurses to ensure he was well looked after in the final weeks of his life.

The man's location

34. The man had a standard cell at the prison and remained there until his final hospital admission in January 2015. Throughout 2014, healthcare staff had recommended to him that he should be admitted to the prison's inpatient unit, but he consistently refused, as he did not want to move from his wing. The clinical reviewer noted that this did not affect his clinical care and that healthcare staff nursed him well on the wing.

35. On 14 January, as the man's condition declined, a nurse from the hospital's palliative care team discussed a possible referral to a hospice with him. Two days later, his condition deteriorated further and he was admitted to hospital. He stayed at the hospital until his death.

36. We are satisfied that the man's location was appropriate throughout his illness and that staff took into account his preference to remain living on his wing as long as possible.

Restraints, security and escorts

37. 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.

38. On 2 December 2014, the man went to hospital for an appointment. Two officers escorted him and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) He was very unwell and had ascites which meant that his mobility was very limited. He used a wheelchair and this was noted on the escort risk assessment. A member of healthcare staff (the name is illegible) recorded in the medical section of the risk assessment that there were no medical objections to the use of restraints. The risk assessment concluded that he was low risk to the public and of escape, yet restraints were used.

39. On 8 December, the man went to hospital and officers restrained him with an escort chain. A member of healthcare staff (the name is illegible) recorded in the health risks section of the person escort record that he was "physically frail".

40. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. Restraints were used for all hospital appointments before the man's final admission in January. However, when he went to hospital in December, he used a wheelchair to get about, was terminally ill, and described as physically frail. We are concerned that not all this information was noted in the healthcare section of the risk assessments and are therefore not satisfied that the prison properly considered this information when authorising the use of restraints, as the 2007 High Court judgment requires. We are pleased to note that he was not restrained when he went to hospital on 15 January or at any time after that.

41. Ultimately, it is the Governor's responsibility to ensure that the risk assessment process is managed properly. However, healthcare staff also need to understand their responsibilities, and have appropriate and considered input into the risk assessment process. We have made recommendations to Elmley before about this issue, and the prison undertook to make changes. We make the following recommendation:

The Governor and Health 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 the man's family

42. On 18 February, the prison asked a prison chaplain to act as the prison's family liaison officer. He called the man's partner to let her know that he was in hospital (although the hospital had already informed her) and that his condition was deteriorating quickly. He helped arrange for her to visit him at the hospital later that day. The man died during the night of 22 February. In the morning, the chaplain and the duty governor visited her, informed her of his death and offered condolences and support.

43. The chaplain kept in contact with the man's partner to support her and helped with funeral arrangements. The funeral was held on 30 March and the prison offered a contribution to the cost, in line with national guidelines.

44. The man had been seriously ill for some time and by November 2014, he had a limited life expectancy and his treatment was palliative. He had several stays in hospital in November and December, before his final admission in January 2015. His partner and his son visited him in hospital on 5 February after the hospital had informed them that he was seriously ill but no one from the prison contacted his family until 18 February.

45. Prison Service Instruction (PSI) 64/2011 says that prisons should have arrangements in place for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill. Similarly, Prison Rule 22 says that prisons should inform the next of kin of prisoners who are seriously ill. The safer custody manager at Elmley told us that it was local protocol to contact the next of kin within 72 hours of a prisoner's

hospital admission. However, if the condition was serious or life threatening, the duty governor would contact them as soon as possible. The prison could not provide any record that they had informed his family of his admission to hospital in January. We make the following recommendation:

The Governor should ensure that a member of staff is appointed to engage with families of terminally or seriously ill prisoners and inform them at once if they are admitted to hospital.

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.

47. At the end of October, doctors told the man he had a thirty percent chance of dying within three months. After receiving this information, Elmley submitted an application for compassionate release to the headquarters of the National Offender Management Service (NOMS) for consideration. During December and January, staff at Elmley updated the application, and on 26 January, a reported that that he had a short prognosis of weeks to months at most. On 30 January, a NOMS official rejected his application as he did not have a clear prognosis and was not bedridden or similarly incapacitated.

48. Although the application was unsuccessful, we are satisfied that the prison appropriately considered and applied for compassionate release. We recognise that until very shortly before his death, there was no clear prognosis of less than three months.

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