Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wojiech Ciesla a prisoner at HMP Whitemoor on 24 May 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*

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ciesla died of liver cancer caused by hepatitis C at a hospice on 24 May while a prisoner at HMP Whitemoor. He was 58 years old. I offer my condolences to Mr Ciesla's family and friends.

Mr Ciesla's death was expected. I am satisfied that he received a good standard of care at Whitemoor, at least equivalent to that he could have expected in the community. However, I consider that a formal end of life policy would enhance the provision for terminally ill prisoners and I am concerned that Mr Ciesla was restrained for his visits and admissions to hospital without appropriate justification.

I would like to commend the prison's family liaison officer for the exceptional standard of support to Mr Ciesla and his next of kin.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **January 2017**

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Summary

Events

1. Mr Wojiech Ciesla was a life-sentenced prisoner who had been at HMP Whitemoor since 1 December 2007. He had a history of liver problems and liver function tests repeatedly showed abnormalities. A hepatology specialist reviewed him at least once a year. Mr Ciesla had also been diagnosed with hepatitis C which was successfully treated.

2. On 25 June 2015 Mr Ciesla reported stomach pain which continued and worsened over several months. Healthcare staff reviewed him and sent him for hospital tests. They also prescribed painkillers to ease his symptoms. In February 2016 a CT scan revealed an abnormality that appeared to be cancer. A month later, the hospital confirmed the diagnosis of terminal hepatocellular carcinoma (liver cancer).

3. Healthcare staff treated Mr Ciesla palliatively, in consultation with a palliative care consultant, Macmillan and community palliative nurses. When his condition worsened they admitted him to the prison's inpatient unit or sent him to hospital when necessary. On 21 May, after a further deterioration in his condition, Mr Ciesla was admitted to hospital. He was transferred to a hospice on 23 May and died at 4.40am the next morning.

Findings

4. We agree with the clinical reviewer that Mr Ciesla generally received a high standard of compassionate care at Whitemoor, equivalent to that he could have expected in the community. However, a formal end of life policy would ensure that staff were better informed of requirements and improve the standard and effectiveness of palliative care.

5. Although risk assessments for Mr Ciesla's hospital appointments and admissions concluded that he was a low risk of escape, at least two escort staff accompanied him, using either double handcuffs or an escort chain. We are not satisfied that the decisions to use restraints took full account of Mr Ciesla's health and mobility and how they affected his risk of escape. We have raised this issue with Whitemoor before.

Recommendations

- The Head of Healthcare should develop an agreed multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care including the use of syringe drivers and delivering appropriate pain relief medication promptly.

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

The Investigation Process

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

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

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

9. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation who gave us the cause of Mr Ciesla's death. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the friend Mr Ciesla had named as his next of kin, to explain the investigation. Mr Ciesla's friend raised no questions or concerns for the investigation to consider

11. The investigation has assessed the main issues involved in Mr Ciesla'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.

12. We shared the initial report with the Prison Service and they found no factual inaccuracies.

13. Mr Ciesla's friend received a copy of the initial report. He was very complimentary about the prison's contact with him and their handling of Mr Ciesla's illness. In particular, he found the staff, chaplain, prison family liaison officer and prisoners respectful and helpful.

Background Information

HMP Whitemoor

14. HMP Whitemoor is a high security prison, which holds over 450 men serving long sentences. NHS East Anglia commissions healthcare services.

15. Since April 2015, Northamptonshire Healthcare NHS Foundation Trust has been the healthcare provider. Primary care, drug misuse services and mental health services are now integrated. The prison healthcare centre has a nine-bed inpatient unit, including a cell for men with palliative and complex care needs.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Whitemoor was in January 2014. Inspectors reported that there was good integrated working between the healthcare services and the wider prison and prisoners had daily access to nurses on the wing. The prison's inpatient unit provided a therapeutic and supportive environment and there were a good range of services.

Independent Monitoring Board

17. 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 May 2016, the IMB reported that there had been a smooth transition after the change of healthcare provider. Although they still relied on agency staff, several permanent nurses had been recruited which should enable better continuity of care.

Previous deaths at HMP Whitemoor

18. Mr Ciesla was the sixth prisoner to die from natural causes at Whitemoor, since the beginning of January 2014. We have raised the issue of the unjustified use of restraints before.

Findings

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

19. Mr Wojiech Ciesla was remanded to HMP Belmarsh on 17 October 2005. At his reception health screen, he reported back pain and liver problems. He also said that he was a heavy drinker and records show that he was treated for alcohol withdrawal. Mr Ciesla was convicted of murder and sentenced to life imprisonment on 13 July 2007. He was transferred to HMP Whitemoor on 1 December 2007.

20. Mr Ciesla was under the care of a consultant hepatologist at hospital, who reviewed him at least once a year. Between 2007 and 2009, Mr Ciesla had liver function tests which indicated abnormalities. He also tested positive for hepatitis C which was successfully treated. At his annual review in January 2014, it was agreed that he did not need to attend for another two years.

21. On 25 June 2015, a nurse referred Mr Ciesla to the prison GP after he reported stomach pain. A prison GP examined him and thought he might be suffering from gastritis or gallstones. She prescribed medication to reduce the acid in his stomach and planned to review him in two weeks if his condition settled and sooner if not. At subsequent reviews, Mr Ciesla said that his pain had increased. In early July, the tests of a stool sample indicated the presence of helicobacter pylori, a bacterial infection which can cause gastritis (inflammation of the stomach lining). He was treated with a combination of antibiotics and stomach acid medication.

22. Over the next few months, Mr Ciesla frequently complained of worsening stomach pain, as well as loose stools. Healthcare staff reviewed him and prescribed strong painkillers and he also took paracetamol. On 16 September, a prison GP re-referred him to the hepatobiliary department at hospital. Although, Mr Ciesla initially ate and drank well, on 12 October 2015 he told a locum prison GP that the pain was worse after eating and drinking, he was nauseous and had vomited.

23. On 13 November, Mr Ciesla attended an outpatient hepatology appointment at hospital and was referred for further tests including ultrasound and CT scans.

24. On 19 January 2016, healthcare staff admitted Mr Ciesla to the inpatient unit due to major abdominal pain. They created a care plan to monitor his pain levels several times a day and gave him painkillers at predetermined intervals.

25. Mr Ciesla had a CT scan on 12 February. On 19 February, a prison GP reviewed the results and noted that there were signs of hepatocellular carcinoma (the most common form of liver cancer). On 3 March a prison GP told Mr Ciesla that the CT scan had revealed an abnormal mass in his liver that was possibly cancer but he was waiting for a further report from the hospital. Mr Ciesla accepted this, but was hopeful that it was not cancer.

26. At a review on 8 March, Mr Ciesla said that his painkiller (tramadol) was giving limited relief, so a prison GP prescribed morphine. The doctor noted that Mr

Ciesla had accepted his provisional diagnosis and wanted help from Macmillan nurses.

27. On 17 March, the healthcare department received a letter from the hospital confirming the diagnosis of terminal liver cancer and stating that Mr Ciesla had been referred to their oncology department. Mr Ciesla had an outpatient appointment that day. While he was at the hospital Sister, the nurse in charge of the prison inpatient unit, received a telephone call from one of the hospital nurses. The nurse explained that Mr Ciesla's cancer was extensive and he was not expected to live for very long.

28. We are satisfied that prison healthcare staff took appropriate steps to investigate Mr Ciesla's symptoms and there was no delay in seeking a diagnosis.

Mr Ciesla's clinical care

29. A nurse arranged to see Mr Ciesla, with an officer, immediately on his return to Whitemoor that afternoon. They discussed his diagnosis, whether he should be admitted to the healthcare centre and considered whether he needed support under suicide and self-harm prevention procedures. She then sought advice from staff at HMP Littlehey about how to refer Mr Ciesla to Macmillan for palliative care and pain relief. She also submitted a form to the GP to refer Mr Ciesla to a hospice. Mr Ciesla said he wanted to continue his job in the kitchen servery and reassured the nurse and the officer that he was coping.

30. On 18 March, a prison GP discussed resuscitation with Mr Ciesla, who said he did not want anyone to resuscitate him if his heart or breathing stopped. The doctor signed an order to that effect. With Mr Ciesla's permission, a notice informing staff of his wishes was placed on display in the wing office, in his cell and the information was circulated to other relevant departments and staff. The GP also increased the dosage of painkillers.

31. On 19 March, an officer noted that Mr Ciesla said he did not have long to live, but wanted to carry on as normal and not discuss it. He was happy to approach staff if he had any problems. He wanted to continue with his wing and servery duties for as long as possible.

32. During the next few days, Mr Ciesla became very short of breath. Healthcare staff examined him and on 22 March a prison GP requested a chest X-ray, which returned as abnormal and was forwarded to Mr Ciesla's oncology team. The GP also telephoned a doctor at the hospice to discuss pain relief. They concluded that Mr Ciesla's pain was well controlled at that time and it would be best to obtain input from Macmillan.

33. On 30 March, a Macmillan nurse visited the prison to see Mr Ciesla and meet various staff members. She advised them to increase his morphine, stop the co-codamol and start additional medication to relieve the side effects of the opioids. She also discussed the possibility of using a syringe-driver which gives a continuous flow of medication under the skin. Healthcare staff informed her that the prison would not allow this and they discussed acceptable alternatives, such as an abbocath catheter (which would administer medication through his vein). The Macmillan nurse continued to visit Mr Ciesla.

34. Healthcare staff adjusted Mr Ciesla’s pain relief to manage his symptoms, in consultation with the Macmillan nurse and a palliative care consultant. He had further CT scans (which indicated abnormal changes in his chest) and a biopsy at hospital. A specialist community palliative care nurse also gave advice by telephone and visited Mr Ciesla.

35. In April, healthcare staff routinely referred Mr Ciesla to the mental health team as he was experiencing anxiety and sleeplessness as a result of diagnosis. On 25 April, a mental health nurse assessed Mr Ciesla and concluded that he had no psychotic symptoms or unusual thoughts. Mr Ciesla said he did not need help from the mental health team and she told him that he could access their services if he changed his mind.

36. On 5 May, a prison GP reviewed Mr Ciesla’s wishes about resuscitation as he was due to undergo further tests and there was the possibility of a change to his prognosis and treatment plan. At Mr Ciesla’s request, the doctor revoked the do not resuscitate order. Mr Ciesla changed his mind on 17 May and asked for the order to be reinstated.

37. The following day, healthcare staff sent Mr Ciesla to hospital as an emergency as he had difficulty breathing and speaking. He remained there until 11 May. Prison healthcare staff frequently contacted the hospital for updates. On his return to the prison, a prison GP prescribed the medications listed in the hospital discharge letter.

38. On 18 May, a nurse created detailed palliative/end of life care and pain management plans. Two days later, staff introduced a soft diet.

39. Mr Ciesla condition deteriorated. He became increasingly confused, agitated, breathless and tired. His oxygen levels fell, he had difficulty swallowing and he was unsteady on his feet. As a result of this, he was admitted to hospital as an emergency at lunchtime on 21 May. Hospital doctors gave conflicting opinions about his condition. An initial assessment by the accident and emergency team indicated described him as very ill and at the end of life stage. A later assessment indicated that he was not at the end of life, but had a chest infection which they would treat. A nurse visited him the next day and noted that the end of life care plan had been implemented.

40. At 4.40am on 24 May, while at a hospice, Mr Ciesla stopped breathing and a doctor recorded his death at 8.50am. His friend was with him when he died.

41. The Coroner gave the cause of Mr Ciesla’s death as hepatocellular carcinoma (liver cancer) caused by hepatitis C infection.

42. The clinical reviewer considered that the overall care Mr Ciesla received at Whitemoor was equivalent to that he could have expected in the community and staff were compassionate and supportive. However, we share her concern that healthcare staff were not initially aware of how to access services such as Macmillan and that Mr Ciesla was not allowed to have a syringe driver for pain relief. There was also no provision for Mr Ciesla’s cell to remain open at night. We agree with the clinical reviewer that Whitemoor should put in place a formal

policy to improve and support end of life care. We make the following recommendation:

The Head of Healthcare should develop an agreed multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care including the use of syringe drivers and delivering appropriate pain relief medication promptly.

43. The clinical reviewer has made additional recommendations which the Head of Healthcare will need to address. We do not repeat them here as they did not directly affect Mr Ciesla's death.

Mr Ciesla's location

44. On 17 March, after confirmation of his diagnosis, Mr Ciesla told a nurse and an officer that he wanted to return to his wing to be with his friends. He knew that he would have to be admitted to healthcare as his illness progressed but said he would tell healthcare staff when he needed to move. On the same day, he told a prison GP that he would consider moving to a hospice if that was an option. When Mr Ciesla began to experience shortness of breath soon afterwards, healthcare staff offered him the opportunity of admission to the inpatient unit. Mr Ciesla moved to the inpatient unit on 29 March and family and friends were allowed to visit him there.

45. Mr Ciesla continued to deteriorate and on 21 May, after consulting the Macmillan nurse, healthcare staff sent him to hospital as an emergency. His condition worsened and he was urgently transferred to a hospice on 23 May.

46. We are satisfied that staff respected Mr Ciesla's wishes to remain on his residential wing for as long as possible. He was appropriately admitted to the healthcare inpatient unit when his condition deteriorated significantly. Staff quickly facilitated admission to hospital and subsequently a hospice when he reached the end of life stage.

Restraints, security and escorts

47. 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.

48. After his diagnosis Mr Ciesla had several hospital outpatient appointments as well as admissions to hospital. Risk assessments concluded that his risk of escape, hostage taking and likelihood of outside assistance were low. His risk to the public and to hospital staff were initially medium but in the latter weeks low.

On each risk assessment healthcare staff ticked to indicate that Mr Ciesla had impaired mobility but that there was no objection to the use of restraints. Confusingly, they also ticked the box to indicate that his medical condition did not restrict his ability to escape unaided. They provided no additional comments about Mr Ciesla's condition.

49. Until 19 May, prison managers authorised the use of double handcuffs for journeys to hospital and during treatment. The number of escort officers varied between two and four. After that date, escort officers used single handcuffs or an escort chain. (Double handcuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs and is usually used for high risk prisoners in good health. 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.)

50. Escort staff recorded in the Person Escort Record which accompanied Mr Ciesla on 21 May that he was clearly in distress. At 7.16pm that day, a nurse noted that the prison would consider removing Mr Ciesla's restraints subject to a further risk assessment. The prison told the investigator that during discussion about removing the restraints the Head of Healthcare advised them that Mr Ciesla still had the physical capacity to escape. On the morning of 22 May, following a request hospital staff, prison managers authorised the escort officers to remove the restraints. We note that Mr Ciesla was again restrained for his final journey to the hospice but the escort chain was removed when he arrived.

51. Mr Ciesla had an advanced terminal illness which had left him weak and confused. For hospital visits he was escorted by at least two prison officers. It seems that there was little meaningful input from healthcare staff in the risk assessments and prison managers took little or no account of how his ailing condition and limited ability affected his risk of escape, as the High Court judgment requires. We are therefore not satisfied that staff appropriately assessed Mr Ciesla's risk. 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 on the use of restraints, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Ciesla's family

52. Mr Ciesla had relatives abroad but none in the UK. His named next of kin was a friend. On 23 March 2016, the prison assigned a member of the administration team as Mr Ciesla's family liaison officer. She introduced herself to Mr Ciesla that afternoon. On 29 March, she telephoned Mr Ciesla's friend to explain her role. They agreed that she could also speak to his friend's wife or adult daughter if he was not available. She spoke to them several times a week to give updates on Mr Ciesla's physical condition and mood and to help arrange visits (which took place every two or three days). She also dealt with special requests from his friends, questions about procedures, and assisted in discussions about his personal affairs and funeral arrangements. Although Mr Ciesla spoke English, she invited a Polish-speaking colleague to attend some meetings to ensure that

he was clear about the processes. She informed his friends immediately of his admissions to hospital and arranged for them to visit him.

53. In the early hours of 24 May, after Mr Ciesla's death, the duty manager went to the hospice with the Deputy Governor and a member of the care team. They offered condolences and support to Mr Ciesla's friend. The family liaison officer telephoned him later that morning to offer additional support. In line with national guidance the prison arranged and paid for Mr Ciesla's funeral, which was held on 8 June. The family liaison officer provided continuing support to Mr Ciesla's friends after his funeral.

54. We commend the family liaison officer for the exceptionally high standard of family liaison during Mr Ciesla's illness.

Compassionate release

55. 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.

56. Doctors had told Mr Ciesla that his cancer was terminal but gave no formal prognosis of how long he might live. There was no evidence that either prison or medical staff sought a view on his life expectancy. While there is no formal record that the prison considered the possibility of compassionate release, the Deputy Head of the Offender Management Unit said that prison staff had discussed this. They had concluded that as Mr Ciesla had not requested compassionate release and there was uncertainty about his life expectancy, it was not in his best interests to pursue this. We acknowledge that as his family was abroad compassionate release would not necessarily have been beneficial to Mr Ciesla and it was unlikely that he would have met some of the other criteria, such as adequate arrangements for his care and treatment. However, in similar cases in the future, the prison might wish to record that they have considered but discounted the possibility of compassionate release and note the reasons why.

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