Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Wiggans a prisoner at HMP Altcourse on 27 June 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Alan Wiggans died from lung cancer that had spread to other parts of his body, at HMP Altcourse on 27 June 2016. He was 56 years old. I offer my condolences to Mr Wiggans' family and friends.

I am satisfied that the healthcare Mr Wiggans received, initially at HMP Stoke Heath and, after his recall to custody, at Altcourse, was equivalent to that he could have expected in the community. Prison healthcare staff made timely referrals to investigate Mr Wiggans' symptoms and, after his diagnosis, they provided supportive and compassionate care to meet his physical and emotional needs.

However, I am concerned that Mr Wiggans was restrained for his visits to hospital towards the end of his life without proper justification and I repeat a previous recommendation on this issue. It is disappointing that I need to do so given that the prison had previously agreed to address the issue.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2017**

Contents

Summary

Events

1. On 11 September 2014, Mr Alan Wiggans was remanded to HMP Altcourse. He was subsequently convicted and sentenced to 26 months in prison. He was moved from Altcourse to HMP Stoke Heath on 6 February 2015. Mr Wiggans had several longstanding medical problems, including chronic obstructive pulmonary disease (COPD – the name of a collection of lung diseases including chronic bronchitis and emphysema).

2. A few days after he arrived at Stoke Heath, Mr Wiggans reported breathlessness. A chest X-ray indicated abnormalities and a prison GP referred him urgently to a respiratory consultant. Tests confirmed that Mr Wiggans had lung cancer and, in May 2015, he had surgery to remove a part of his lung. In July, further tests revealed that the cancer had spread to his lymph nodes and was incurable. Mr Wiggans delayed and subsequently declined chemotherapy. In August, Mr Wiggans was released on licence.

3. At the beginning of March 2016, Mr Wiggans was recalled to prison and taken to Altcourse. Healthcare staff admitted him to the inpatient unit and managed his palliative care in consultation with oncology and palliative care specialists. Mr Wiggans also received counselling and support from the mental health team.

4. Mr Wiggans was initially reluctant to see a specialist. When staff found it increasingly difficult to manage his pain, he agreed to referrals to the lung and palliative care departments at Aintree University Hospital, where he attended outpatient appointments in May and June. Escort staff used restraints for most of his appointments. Mr Wiggans was due to receive palliative radiotherapy but died on 27 June before it started.

Findings

5. The investigation found that prison healthcare staff took prompt and appropriate steps to investigate Mr Wiggans' respiratory problems and this led to a timely diagnosis of his cancer. We are satisfied that staff subsequently provided a good standard of care, in consultation with oncology and palliative care specialists, equivalent to that Mr Wiggans could have expected in the community.

6. Mr Wiggans was restrained during all but one of his visits to hospital in the last few weeks of his life. We are not satisfied that the prison fully took into account his health and mobility when assessing his risk.

Recommendation

- The Director 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 a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

8. The investigator obtained copies of relevant extracts from Mr Wiggans' prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Wiggans' clinical care at the prison.

10. We informed HM Coroner for Liverpool and Wirral of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers attempted to contact Mr Wiggans' brother who he had listed as his next of kin, to explain the investigation and to ask if he had any matters for the investigation to consider. She received no response.

12. The investigation assessed the main issues involved in Mr Wiggans' 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.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Altcourse

14. HMP Altcourse is a local prison in Liverpool, which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 sentenced and remanded adult and young adult men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that prisoners had satisfactory access to most health services. There was a good range of clinical and screening services. Prisoners were generally positive about the care provided, especially in the inpatient unit. There were good arrangements for palliative and end of life care.

Independent Monitoring Board

16. 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 the appointment of a new GP practice with wide experience of prisons had led to improvements. Locum GPs were no longer necessary, there was a more consistent approach to providing medication and waiting lists had reduced.

Previous deaths at HMP Altcourse

17. Mr Wiggans was the tenth prisoner to die of natural causes at Altcourse since May 2014. There has been a subsequent death from natural causes. We have previously raised with the prison the issues of risk assessments and the use of restraints.

Findings

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

18. On 11 September 2014, Mr Alan Wiggans was remanded to HMP Altcourse. He had a history of alcohol and drug misuse and had been in prison before. Mr Wiggans was subsequently convicted of actual bodily harm and witness intimidation. On 5 November, he was sentenced to 26 months imprisonment.

19. On 6 February 2015, Mr Wiggins transferred to HMP Stoke Heath. During his initial health screen, a nurse recorded that he had several existing medical conditions including COPD and asthma which were managed with inhalers. He declined help to stop smoking.

20. At a COPD review on 10 February 2015, Mr Wiggans reported he was increasingly short of breath and a nurse referred him to the prison GP. A doctor examined Mr Wiggans on 27 February and requested a chest X-ray. On 18 March, the doctor noted that the X-ray results were suggestive of lung cancer. He urgently referred Mr Wiggans to a respiratory consultant at the Princess Royal Hospital, Telford, under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. On 24 March, the respiratory consultant told Mr Wiggans it was likely that he had lung cancer and arranged further tests to find out the specific type and if it had spread.

21. On 26 March, Mr Wiggans and his offender supervisor discussed his provisional diagnosis. The offender supervisor agreed to visit him weekly and asked the chaplaincy team to provide additional support. The same day, a nurse told Mr Wiggans that she was his designated point of contact for questions but that he could speak to any nurse if he had concerns.

22. While waiting for confirmation of the diagnosis, a doctor and prison healthcare nurses often spoke to Mr Wiggans about how he felt. They prescribed antidepressants and medication to help him sleep and asked discipline staff to regulate his work tasks to allow him to work at a slower pace. As he became low in mood and increasingly anxious, they created anxiety care plans and referred him for counselling. Mental health staff also reviewed him weekly.

23. On 16 April, the hospital diagnosed that Mr Wiggans had two tumours in his right lung and referred him to a consultant thoracic surgeon at the Royal Stoke University Hospital. At an appointment on 30 April, the consultant confirmed the diagnosis. They discussed treatment options and risks and he strongly advised Mr Wiggans to stop smoking before having surgery.

24. Prison healthcare staff liaised with the hospital to prepare Mr Wiggans for surgery. In particular, they actively encouraged and supported him to stop smoking and to increase his exercise to improve his lung function. They frequently checked progress on a date for his operation.

25. Between 25 May and 8 June, Mr Wiggans was in hospital for surgery to remove part of his lung. Prison staff kept in touch with the hospital for updates on his condition. Before he returned to the prison, a nurse had a handover with the

ward staff nurse. Prison nurses carried out post-operative monitoring and care and consulted hospital staff about dietary needs and nutritional supplements.

26. On 15 July, a consultant clinical oncologist at Royal Shrewsbury Hospital told Mr Wiggans that his cancer was terminal and had spread to his lymph nodes. He recommended chemotherapy and planned to start the following week.

27. We are satisfied that after Mr Wiggans reported deteriorating respiratory symptoms, prison healthcare staff appropriately assessed him and quickly referred him to a specialist, in line with national guidelines. We agree with the clinical reviewer that there was effective and supportive communication with Mr Wiggans about his diagnosis and prognosis.

Mr Wiggans' clinical care

28. During a discussion on 16 July, Mr Wiggans told a nurse that chemotherapy would give him a life expectancy of around 12 months but he was so devastated that he had forgotten to ask the consultant how long he might live if he did not have it. The same day, he asked for the treatment to be delayed until 11 August.

29. Nurses reviewed Mr Wiggans daily and dispensed medication to manage his shortness of breath and pain. They monitored his nutrition and weight; facilitated baths; generally checked his wellbeing; and fully documented discussions held for emotional support and reassurance. The prison doctor examined Mr Wiggans when he reported additional symptoms and adjusted his medication. The mental health team also continued to support him. Wing staff conducted additional checks at night in case he needed help.

30. During a review on the morning of 31 July, a doctor raised the issue of resuscitation and Mr Wiggans said he did not want to be resuscitated if his heart or breathing stopped. The doctor asked a nurse to speak to Mr Wiggans before implementing an order. At lunchtime, after discussion with the nurse, Mr Wiggans changed his mind as he was happy with his quality of life and the doctor noted this in his records.

31. On 6 August 2015, HMP Stoke Heath released Mr Wiggans on home detention curfew (HDC). This allowed him to live in the community with an electronic tag that was due to be removed in October 2015. A prison administrator contacted Mr Wiggans' community GP's surgery to inform them of his diagnosis and forwarded his medical record. She also spoke to his oncologist's secretary to give his new address and GP's details.

32. On 4 March 2016, Mr Wiggans' licence was revoked due to poor behaviour. He was recalled to prison and taken to Altcourse on 5 March 2016. At his initial health screen, a nurse noted his previous medical history, his terminal lung cancer and outstanding hospital appointments. A prison GP assessed him immediately afterwards. The doctor prescribed medication for alcohol detoxification and admitted Mr Wiggans to the healthcare inpatient unit due to his poor physical health.

33. Healthcare staff requested Mr Wiggans' records from his community GP and St Kentigern Hospice where he had received palliative care before he returned to prison. Prison doctors examined him daily pending receipt of the medical

information. They recorded that Mr Wiggans had declined chemotherapy but had agreed to palliative radiotherapy. On 10 March, a prison GP spoke to a palliative care consultant and noted the need to review the extensive hospice notes. Counselling and mental health sessions continued.

34. On 23 March, the palliative care consultant visited the prison to review Mr Wiggans' symptoms and to advise staff on his care. During their discussion, Mr Wiggans confirmed that he did not want to be resuscitated. The consultant completed and signed an order to that effect.

35. Healthcare staff continued to closely review and monitor Mr Wiggans' palliative care. He also received counselling. Mr Wiggans became unsteady on his feet and needed a wheelchair to move between the inpatient unit and other areas of the prison. Initially, he said he did not want see a specialist. However, at a review with a doctor on 12 May he agreed to an oncology referral as his pain had become hard to manage in spite of increased pain relief.

36. In May and June, Mr Wiggans attended outpatient appointments at the lung and palliative care clinics and the CT department at Aintree University Hospital to determine the progression of the cancer. Although he agreed to palliative radiotherapy, he wanted to be sure that his treatment could be transferred to the cancer centre in the community where he was previously treated, as he expected to be released within a few months. (He died before the treatment started.)

37. Late evening on 6 June, a doctor diagnosed possible pneumonia but Mr Wiggans refused to go to hospital. The next morning, healthcare staff persuaded him to go as an emergency, but he discharged himself later that day.

38. Just after 5.45am on 27 June, during the morning check of prisoners, two nurses found Mr Wiggans unresponsive. In line with Mr Wiggans' wishes, they did not attempt resuscitation. Paramedics attended and, at 6.10am, recorded that Mr Wiggans' had died. A doctor also went to the prison and confirmed the death at 8.06am.

39. The coroner accepted Mr Wiggans' cause of death as metastatic lung cancer (lung cancer that had spread to other parts of his body).

40. The clinical reviewer concluded that Mr Wiggans received timely, compassionate and responsive end of life care that addressed his physical and emotional needs and allowed him to die in comfort and with dignity. He received a good standard of care, equivalent to that he could have expected in the community.

Mr Wiggans' location

41. When he returned to prison on 5 March, Mr Wiggans was initially admitted to the healthcare centre. On 17 March, he moved to the ground floor of a residential wing. He was readmitted to the inpatient unit three days later as he had struggled on the residential wing due to increasing pain and was unable to walk to the healthcare centre for his painkillers. Although Mr Wiggans was later keen to return to a wing, after a discussion with a doctor on 30 March he accepted that it would not be practical as he would have difficulty collecting his medication and using a nebuliser in his cell. He also felt he could be vulnerable to bullying because of his medication.

42. On 6 June, when Mr Wiggans' condition worsened, prison managers allowed healthcare staff to keep his cell open overnight so that it would be easier for them to check and treat him.

43. We are satisfied that while respecting Mr Wiggans' wishes, healthcare staff appropriately encouraged him to remain in the inpatient unit and to go to hospital for further investigation when necessary.

Restraints, security and escorts

44. 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.

45. Mr Wiggans had a history of alcohol-related violent offending. However, prison staff described him as quiet, easy-going and compliant. As his illness worsened, he became less mobile and used a wheelchair to get around the prison. Security risk assessments for Mr Wiggans' hospital appointments in May and June 2016, concluded that his risk of escape, hostage taking and likelihood of outside assistance were low but he was a high risk to the public. Healthcare staff ticked the medical section of the assessments to indicate that Mr Wiggans had the ability to escape unaided and that there were no objections to the use of double cuffs or an escort chain during treatment. With the exception of the form completed on 7 June, they provided no information about his medical condition.

46. For each hospital appointment, prison managers instructed officers to restrain Mr Wiggans with double or single handcuffs and an escort chain during treatment. (Double cuffing 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. 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). Person escort records indicated that Mr Wiggans was fully cooperative during the journeys and hospital visits, including an emergency admission on 7 June when restraints were not used. However, on 16 June prison managers again specified the use of single handcuffs for an outpatient hospital appointment.

47. We are not satisfied that the risk assessments took sufficient account of Mr Wiggans' poor health and mobility and the impact on his risk of escape, as the High Court judgment requires. We make the following recommendation:

The Director 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 a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Wiggans' family

48. Staff at Stoke Heath facilitated contact between Mr Wiggans and his family, including a private telephone call from the chapel on 16 July 2015 to tell his brother about his diagnosis. They arranged for him to live with his brother when he was released in August 2015.

49. At Altcourse, a prison manager in the safer custody team, initially acted as Mr Wiggans' family liaison officer. On 8 June 2016, they discussed family contact. Mr Wiggans said he did not want to keep in touch with his family or friends and had already planned his future care at a hospice once released. Two weeks later, she asked again about family contact and Mr Wiggans agreed that she could telephone his brother. She called several times over the next few days, but there was no response.

50. After Mr Wiggans' death on 27 June, a reverend was assigned as the family liaison officer. During the morning, the family liaison officer and a prison custody officer went to notify Mr Wiggans' brother. As his brother was on holiday, they informed Mr Wiggans' nephew (his brother's son) of his death and offered support. In the afternoon, the family liaison officer spoke to other family members and friends.

51. In line with national policy, the prison contributed to the costs of Mr Wiggans' funeral, held on 21 July. We are satisfied that the prison liaised appropriately with Mr Wiggans' family.

Compassionate release

52. 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.

53. Prison managers at Stoke Heath secured early release for Mr Wiggans on HDC. A doctor formally supported this as he felt Mr Wiggans' health and social needs would be better addressed in the community. A nurse and someone from NACRO housing and a senior officer from the prison's Offender Management Unit liaised to arrange suitable accommodation and carer support.

54. After his recall to prison, Mr Wiggans was due to be released in November 2016. In view of his illness, the prison asked the Parole Board to consider him for re-release sooner, but Mr Wiggans died before the parole hearing scheduled for 17 August. We are satisfied that the prison actively sought early release.

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