Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Scott a prisoner at HMP Littlehey on 25 September 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 Colin Scott died of bronchopneumonia and bronchitis at a hospice on 25 September 2016 while in the custody of HMP Littlehey. He was 74 years old. I offer my condolences to Mr Scott's family and friends.

Overall, I am satisfied that the healthcare Mr Scott received at Littlehey was at least equivalent to that he would have received in the community. However, I repeat previous recommendations that Littlehey should treat urgent referrals more promptly. I am also concerned that the prison submitted an incomplete application for compassionate release, which meant that release could not be considered.

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 **March 2017**

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Summary

Events

1. On 5 December 2014 Mr Colin Scott was sentenced to 11 years imprisonment for sexual offences and sent to HMP Norwich. On 2 April 2015, Mr Scott transferred to HMP Littlehey.

2. On arrival into custody, healthcare staff noted Mr Scott had a number of long-term medical conditions, including prostate cancer, high blood pressure and high cholesterol. Healthcare staff created care plans and reviewed Mr Scott's medication. While at Littlehey, Mr Scott was diagnosed with chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and he developed venous ulcers in his feet, which prison healthcare and hospital staff treated.

3. On 7 April, five days after arriving at Littlehey, a doctor requested an urgent two week referral to the urology service regarding Mr Scott's on-going prostate cancer care and management. An oncologist did not see Mr Scott until 21 May.

4. On 24 September, Mr Scott had a follow up appointment with his consultant oncologist, who prescribed a hormonal therapy drug to treat his prostate cancer.

5. On 8 January 2016, Mr Scott had a coronary heart disease review. A nurse noted that Mr Scott was in poor health with swelling in both his legs. Two days later, a doctor noted that Mr Scott's prostate-specific antigen (PSA – a protein produced by the prostate gland, which is raised in men with prostate cancer) had increased and informed Mr Scott's consultant oncologist.

6. In April and May, Mr Scott suffered two falls. A doctor asked Mr Scott's consultant oncologist whether they were caused by a spread of his cancer. On 20 May, a doctor sent Mr Scott to hospital because he could not move or feel his legs. While in hospital, doctors found a tumour compressing Mr Scott's spine, which caused paralysis from the waist down. They treated Mr Scott with radiotherapy and referred him to the palliative care team.

7. After Mr Scott completed a course of radiotherapy, on 6 June, his consultant oncologist told him there was no further treatment available and that he needed to be discharged to a prison with 24-hour healthcare. Mr Scott wanted to return to Littlehey where the prison arranged support from a prisoner carer and a social worker. The hospital discharged Mr Scott on 5 July.

8. On 12 July, a doctor explained to Mr Scott that he might need to transfer to a hospice for end of life care, as his condition declined. Mr Scott spent two periods in a hospice; the first between 25 July and 16 August, and the second from 29 August until his death at 4.00am on 25 September.

Findings

9. The clinical reviewer found that the care Mr Scott received was at least equivalent to that he could have expected to receive in the community. Healthcare staff managed Mr Scott's conditions and his end of life care

effectively. They also gave him regular medical and emotional support and fully involved him in decisions about his care.

10. While the care that Mr Scott received was good, we are concerned that there were administrative delays in organising an urgent appointment in April 2015, and sending a referral letter to a specialist in May 2016. These delays did not affect the outcome for Mr Scott, but could be crucial in other circumstances.

11. We are concerned that the prison submitted an application for compassionate release without a medical report from the specialist who was treating Mr Scott. The Public Protection Casework Section told the prison on two occasions that they could not consider Mr Scott's application without this information yet the prison did not provide it before his death.

Recommendations

- The Head of Healthcare should ensure that all urgent referrals are sent within 24 hours, monitored and followed up as necessary.
- The Governor should ensure that all compassionate release applications are complete and supported by all necessary information, including medical reports from specialists, before they are submitted.

The Investigation Process

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

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

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

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

16. One of the Ombudsman's managers wrote to Mr Scott's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Scott's daughter-in-law responded but did not have any matters that she wanted the investigation to consider.

17. The investigation has assessed the main issues involved in Mr Scott'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.

18. Mr Scott's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

19. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Littlehey

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

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

Her Majesty's Inspectorate of Prisons

22. The most recent inspection of HMP Littlehey was in March 2015. Inspectors noted that an experienced nurse manager and two senior nurses provided effective clinical leadership. Despite chronic problems in recruiting nursing staff, health services had not been affected as regular highly skilled agency staff filled any shortfalls. A small group of regular GPs had significantly improved patient care and they each had an identified specialism, including chronic pain management. Prisoners with lifelong conditions were identified effectively and nurses with additional specialist training provided relevant clinics. There was excellent and compassionate joint working between the health provider, prison and community services for prisoners with palliative care and end-of-life needs.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2016, the IMB reported that the transfer to a new healthcare provider in April 2015 went smoothly with no adverse impact on service delivery.

24. The IMB recognised the significant demands the elderly prison population made upon healthcare services, in particular the increasing number of hospital escorts, subsequent stays and the resulting risks associated with the redeployment of staff. They also reported that many prisoners have multiple disabilities and all parts of the prison are accessible for wheelchair users or reduced mobility prisoners.

Previous deaths at HMP Littlehey

25. Mr Scott was the twelfth person to die of natural causes at Littlehey since January 2015. Two people have died since. We have raised the issue of processing referrals before.

Findings

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

26. On 5 December 2014, Mr Scott was sentenced to 11 years imprisonment for sexual offences and was sent to HMP Norwich. Healthcare staff noted Mr Scott suffered from prostate cancer (diagnosed in 2003), hypertension (high blood pressure), hypercholesterolemia (high levels of cholesterol in his blood) and osteoarthritis in his wrists, fingers and left knee. He moved with the aid of a crutch. Healthcare staff created care plans and completed a falls risk assessment. They also prescribed Mr Scott various medications for his conditions, which included nifedipine, atenolol and ramipril (for hypertension), simvastatin (to lower his cholesterol) and tamsulosin (for an enlarged prostate). Mr Scott also developed venous ulcers in his feet, which prison healthcare and hospital staff treated.

27. On 2 April 2015, Mr Scott was transferred to HMP Littlehey. A prison GP reviewed Mr Scott on 7 April and requested an urgent two week referral to the urology service at hospital in respect of Mr Scott's on-going prostate cancer care and management. The referral was typed on 9 April but on 22 April a prison GP noted no response had been received from the hospital and asked for the administration team to chase the referral as Mr Scott was due his six-monthly hormone injection (used in the management of prostate cancer). A nurse noted that Mr Scott received his decapeptyl hormone injection on 30 April.

28. On 21 May, a consultant oncologist saw Mr Scott at hospital and continued his current hormone injection regime. The consultant planned to review Mr Scott in four months time.

29. On 23 July, a prison GP reviewed Mr Scott's blood test results and noted his prostate specific antigen level (PSA – a protein produced by the prostate gland, which is raised in men with prostate cancer) was 15.42ug/L (normal levels for those over 70 years old are less than 5.8ug/L). She informed Mr Scott's consultant oncologist by letter.

30. On 29 July, Mr Scott complained that he became breathless on exertion and was coughing up thick sputum in the mornings. A prison GP noted Mr Scott smoked three cigarettes a day and diagnosed chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He requested an x-ray and a spirometry test (to help diagnose and monitor lung conditions) and prescribed Mr Scott salbutamol (an inhaled medication which opens up the airways in the lungs). While Mr Scott was a light smoker, there was no evidence that the GP offered any smoking cessation advice.

31. On 9 September, a prison GP saw Mr Scott to assess his mental capacity, as he wished to give power of attorney to his son. She found that Mr Scott was fully aware of what he was asking for and that he was not being pressurised into making this decision.

32. On 24 September, Mr Scott attended a follow up appointment with his consultant oncologist, who added bicalutamide (an anti-cancer drug) to Mr Scott's medication regime as his PSA level was now 19.45 ug/L.

33. On 22 October, Mr Scott started attending the Crayfish cancer support group and he attended sessions every two months.

34. On 30 December, a prison GP reviewed Mr Scott's COPD. During the review, Mr Scott said he had stopped smoking and used his inhaler.

35. On 4 January 2016, a nurse issued Mr Scott a TENS machine (a method of pain relief by using a mild electrical current), as she had concerns with his overuse of co-codamol (a pain killer).

36. On 8 January, a nurse examined Mr Scott for his coronary heart disease review and arranged to see him again in six months time. She noted that Mr Scott was in poor health with swelling in both his legs, so performed blood tests. Two days later, a prison GP reviewed Mr Scott's blood test results, noted that his PSA level had increased to 24.2 ug/L and informed Mr Scott's consultant oncologist.

37. On 1 March, a prison GP reviewed Mr Scott in the elderly care clinic and noted that he had yet to be reviewed by the oncology team regarding his prostate cancer. There was no evidence that the GP took any action in relation to the outstanding oncology appointment.

38. On 29 April and 12 May, Mr Scott suffered two falls. After the first fall, paramedics raised concerns that the size of Mr Scott's cell and his inability to use the wheelchair in it caused his fall. However, Mr Scott declined an offer to move to a larger cell. After the second fall, a prison GP wrote to Mr Scott's consultant oncologist asking whether the falls were caused by a spread of his cancer. Healthcare staff did not send the letter until 23 May.

39. On 20 May, a prison GP examined Mr Scott, as he had severe back pain and could not move or feel his legs. The GP sent him to hospital, and doctors performed a magnetic resonance imaging (MRI) scan, which showed a tumour compressing Mr Scott's spine. The hospital treated Mr Scott with radiotherapy and referred him to the palliative care team for symptom and pain control and psychological support. On 26 May, a MacMillan nurse noted that the metastatic spinal cord compression was a life-limiting condition and that Mr Scott did not want staff to resuscitate him in the event that his heart or breathing stopped.

40. On 6 June, Mr Scott's consultant oncologist informed him that there was no further treatment for him.

41. We agree with the clinical reviewer that the care Mr Scott received at Littlehey was at least equivalent to that he could have expected to receive in the community. Healthcare staff immediately recognised and managed his on-going healthcare needs. Healthcare staff gave Mr Scott regular care and support, and the Crayfish group provided him with emotional and psychosocial support.

42. While, overall, the care that Mr Scott received at Littlehey was good, we are concerned that there were administrative delays in sending referral letters to specialists. The first occurred when a prison GP referred Mr Scott to urology on

7 April 2015 but he had not received an appointment by 22 April. The second occurred when a prison GP referred Mr Scott to his oncology consultant on 12 May 2016 but the prison did not send the letter for a further 11 days. While this did not affect the outcome for Mr Scott, we are concerned about the impact that these delays could have in the future and are concerned that we have made a similar recommendation in the past. We make the following recommendation:

The Head of Healthcare should ensure that all urgent referrals are sent within 24 hours, monitored and followed up as necessary.

Mr Scott's clinical care

43. Mr Scott was still in hospital when his consultant oncologist told him that he would not receive any more treatment. During the conversation, the oncologist told Mr Scott that the hospital wanted to discharge him to a prison with 24-hour healthcare. However, Mr Scott told a MacMillan nurse that he wanted to return to Littlehey so he could maintain contact with his family.

44. In order to facilitate a return to Littlehey, the prison asked a senior social worker and an occupational therapist to assess Mr Scott's needs and whether there was a suitable cell in the prison. They agreed that a wheelchair cell would be appropriate and that social services would visit Mr Scott four times a day. On 5 July, the hospital discharged Mr Scott.

45. On 6 May, a prison GP saw Mr Scott for a palliative care review. She noted that he was unable to walk and that he found the food unpalatable. She arranged for Mr Scott to receive 'souper' soups (high protein soups) and gave him oramorph (pain relief). During the review, Mr Scott said he wanted to go to a hospice for symptom relief and to die.

46. The following day, the nurse manager visited Mr Scott and felt that the wheelchair cell, although spacious, was not an appropriate environment. She recommended that he move to the intermediate care suite and he agreed to this. The prison also appointed a prisoner carer, who visited Mr Scott three times a day to attend to his day-to-day needs.

47. On the same day, a palliative care consultant visited Mr Scott for a palliative care review. Mr Scott told her that prison healthcare staff had managed his pain and social care needs well and that his consultant oncologist had given him a prognosis of six months to two years. Mr Scott also reiterated that he wanted to die in a hospice and that he did not want staff to resuscitate him.

48. A prison GP examined Mr Scott on 12 July. He said that he now wanted to stay at Littlehey. The GP explained that the prison would try to honour his wishes but if they could not adequately care for him, he might need to go to the hospice. Mr Scott said he understood this.

49. On 20 July, Mr Scott's son and daughter-in-law visited. They were concerned with Mr Scott's condition and wanted him moved to a hospice. The nurse manager explained that at that time Mr Scott did not need hospice care, but when he did the prison would move him to a hospice.

50. The following day, the palliative care consultant visited Mr Scott. She noted Mr Scott had deteriorated with a loud deep cough and increasing shortness of breath. She started him on an oxygen concentrator and a course of antibiotics.

51. On 25 July, Mr Scott's condition deteriorated further and the nurse manager decided that he needed to go to a hospice. Mr Scott went to a hospice on the same day.

52. By 3 August, Mr Scott's condition had improved and the palliative care consultant wanted to discharge him back to Littlehey. Healthcare staff contacted social services so that they could restart their care services and ordered an oxygen concentrator. Mr Scott returned to Littlehey on 16 August, though a prison GP felt that his frailty and confusion meant that Mr Scott may not be able to self administer his medication and that he ideally required 24-hour nursing care.

53. Three days later, the palliative care consultant visited Mr Scott for a palliative care review and noted he had declined since leaving the hospice. The prison agreed to keep Mr Scott's cell door open so that staff could easily access him.

54. Mr Scott's condition deteriorated and, on 29 August, a nurse noted that he was barely responsive. Mr Scott said he was not in pain but he did not want to take his medication. She decided to send Mr Scott back to the hospice.

55. On 13 September, hospice staff told the nurse that Mr Scott's condition had improved and that they wanted to discharge him to a prison with 24-hour healthcare. The nurse manager contacted HMP Bedford, HMP Chelmsford, HMP Norwich and HMP Peterborough over the next few days but none of them had any vacant beds.

56. On 22 September, the hospice contacted healthcare to inform them that Mr Scott had deteriorated overnight and they had contacted his family. Mr Scott continued to deteriorate and he died at approximately 4.00am on 25 September.

57. A post-mortem report confirmed that Mr Scott died from bronchopneumonia and bronchitis caused by COPD and contributed to by congestive heart failure, hypertensive heart disease, disseminated prostate cancer and paraplegia.

58. We agree with the clinical reviewer that the prison managed Mr Scott's end of life care effectively. The palliative care Mr Scott received from the healthcare team in partnership with the hospital's oncology team, social services and the hospice was good. We are pleased that Mr Scott appeared to have been fully engaged decisions about his care and that prison healthcare staff respected his wishes at all times.

Mr Scott's location

59. Before going to hospital in May 2016, Mr Scott lived appropriately in a normal prison cell. When the hospital discharged him on 5 July, he was initially located in a wheelchair cell, a double sized cell, with a hospital bed. Two days later, the nurse manager recommended that Mr Scott move to the intermediate care suite, as she believed that it would be more appropriate and he agreed to the move.

60. When Mr Scott's condition deteriorated, the prison arranged for him to be admitted to the hospice on two occasions. The prison also contacted four local prisons, with 24-hour healthcare, as they would have been more suitable for Mr Scott but none of them had any vacant healthcare beds.

61. We are satisfied that the prison appropriately located Mr Scott throughout the different stages of his condition.

Restraints, security and escorts

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

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

64. Due to Mr Scott's age, mobility and health, when Mr Scott went to hospital and to the hospice, prison managers authorised officers not to restrain him. We are satisfied that these decisions were appropriate.

Liaison with Mr Scott's family

65. When Mr Scott returned from hospital on 5 July 2016, the prison appointed a Senior Officer (SO) and a senior prison manager as his family liaison officers. The SO introduced herself to Mr Scott that day and to his son and daughter-in-law the following day. She arranged for them to visit Mr Scott in prison and the hospice. Mr Scott's family were also regularly kept informed about his condition.

66. Shortly after Mr Scott's death, a prison manager contacted his son and daughter-in-law to break the news of his death. Later that day, the SO offered to meet Mr Scott's son and daughter-in-law at the hospice, but they rejected this offer. She did speak to Mr Scott's son and daughter-in-law on the telephone and offered her condolences and support.

67. Mr Scott's funeral was held on 26 October, and the prison contributed to the funeral costs in line with national policy.

Compassionate release

68. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Further information on release on compassionate grounds is also considered in PSO 3050, for continuity of healthcare. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and

treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

69. On 2 August 2016, an officer started an application for compassionate release. Two days later, a prison GP completed the medical section of the application and noted it was hard to give a prognosis as Mr Scott had recovered and was off the end of life pathway. She gave a prognosis of six months but recognised that it could be as much as two years. On 17 August, Mr Scott's Offender Manager completed the paperwork and returned it to the officer. At this stage, Mr Scott had recovered sufficiently to be discharged from the hospice back to Littlehey.

70. On 29 August, Mr Scott returned to the hospice and the prison resumed his compassionate release application. On 5 September, a Governor supported Mr Scott's compassionate release and the officer submitted it to PPCS, three days later, for a decision. The following day, PPCS found that the application was missing a report from the specialist who was treating Mr Scott and asked the prison for this. PPCS made a second request for this report a week later but the prison did not provide it before Mr Scott died on 25 September.

71. We are concerned that Littlehey did not act promptly when PPCS contacted them on two occasions to explain that the compassionate release application was incomplete. We make the following recommendation:

The Governor should ensure that all compassionate release applications are complete and supported by all necessary information, including medical reports from specialists, before they are submitted.

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