

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Kirkham a prisoner at HMP Altcourse on 1 January 2017

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

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Robert Kirkham died from kidney cancer that had spread to other parts of his body, on 1 January 2017, while a prisoner at HMP Altcourse. He was 66 years old. I offer my condolences to Mr Kirkham's family and friends.

Throughout Mr Kirkham's illness, healthcare staff and wing officers provided timely, responsive and compassionate support, in consultation with palliative care specialists. I am satisfied that his care was equivalent to that he could have expected in the community.

However, I am concerned that an application for compassionate release was not given sufficient priority and that the security risk assessments justifying the use of restraints on Mr Kirkham for his hospital visits did not take full account of his poor health, a matter I have raised with the prison before.

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

July 2017

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Summary

Events

1. Mr Robert Kirkham was sentenced to life imprisonment in 1982. He was released on licence twice, but committed further offences. After his recall to prison on 19 December 2013, Mr Kirkham was taken to HMP Altcourse. At initial health screens, healthcare staff noted his existing medical conditions, including the removal of his left kidney due to renal cancer in January 2013. They arranged for Mr Kirkham's secondary care to be transferred to a local hospital, where specialists continued to monitor him.
2. On 9 September 2014, a consultant oncologist informed Mr Kirkham that the cancer had spread to his lungs and was incurable. He estimated that Mr Kirkham might live for up to two years and gave him treatment to slow down and control the disease. On 8 November 2016, a scan showed the cancer had spread to his liver and bones. He received palliative treatment and healthcare staff implemented appropriate care plans, but his condition worsened and staff began end of life care on 28 November. Mr Kirkham died at 12.58am on 1 January 2017 and a locum GP certified his death at 4.15am.

Findings

3. Prison healthcare staff managed Mr Kirkham's condition appropriately, in close consultation with palliative care and oncology specialists. Along with wing staff, they also provided good support to meet his emotional and physical needs. We agree with the clinical reviewer that Mr Kirkham received a high standard of care, equivalent to that he could have expected in the community.
4. The investigation found shortcomings in the recording of Mr Kirkham's wishes about early release on compassionate grounds and prison staff did not provide the necessary medical information to enable his offender supervisor to conduct a full risk assessment.
5. Mr Kirkham attended a number of hospital appointments. The medical information in the security risk assessments justifying the use of restraints was sparse, with insufficient details about his condition. Therefore, we are not satisfied that the risk assessments fully reflected the debility caused by his ill health and how this impacted on his risk at the time of the hospital visits.

Recommendations

- The Director and Head of Healthcare should ensure that all staff completing and authorising risk assessments, justifying the use of restraints on 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 Director should ensure that terminally ill prisoners' preferences about early release on compassionate grounds are clearly recorded; and applications are completed in full and progressed without delay.

The Investigation Process

6. 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.
7. The investigator obtained copies of relevant extracts from Mr Kirkham's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Kirkham's clinical care at the prison.
9. We informed HM Coroner for Liverpool and Wirral of the investigation who gave us the cause of Mr Kirkham's death. We have sent the coroner a copy of this report.
10. The investigator wrote to Mr Kirkham's sister to explain the investigation. She had no specific matters for the investigation to consider.
11. The investigation has assessed the main issues involved in Mr Kirkham'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.

Background Information

HMP Altcourse

13. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young 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

14. 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

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 June 2016, the IMB reported that a new GP practice with wide experience of prisons had improved primary care services. There was a more consistent approach to providing and reviewing medication and GP waiting lists had reduced.

Previous deaths at HMP Altcourse

16. Mr Kirkham was the tenth prisoner to die of natural causes at Altcourse since January 2015. We have previously raised the issue of poorly completed risk assessments in support of the use of restraints.

Findings

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

17. Mr Robert Kirkham was sentenced to life imprisonment for murder, on 29 April 1982. Mr Kirkham was released on licence twice, but returned to prison after convictions for sexual offences.
18. In January 2013, while living in the community, Mr Kirkham was diagnosed with renal cancer. Surgeons removed his left kidney and monitored him for signs of recurrence or spread of the cancer. In September 2013, a CT scan revealed two nodules in his lungs and a consultant recommended a further scan in one year.
19. Mr Kirkham was recalled to prison and arrived at Altcourse on 19 December 2013. At initial health assessments, healthcare staff noted his previous cancer treatment and other existing medical conditions, including asthma and chronic obstructive pulmonary disease (COPD – the name for a collection of chronic lung diseases, including chronic bronchitis and emphysema). They also requested Mr Kirkham's previous medical records and the outcome of an X-ray taken just before his return to prison. During the following months, prison GPs requested further tests and the management of Mr Kirkham's kidney disease transferred to a consultant urologist at the hospital.
20. On 11 August 2014, the consultant urologist referred Mr Kirkham to a Cancer Centre, as a CT scan had shown further nodules in his lungs. On 9 September, a consultant oncologist at the Cancer Centre told Mr Kirkham that the cancer had spread to his lungs; it was life-limiting and any treatment would control rather than cure the cancer. (The consultant subsequently wrote to the prison.) At that time, the consultant estimated a life expectancy of one to two years, possibly longer. After his hospital appointment, a nurse discussed the diagnosis with Mr Kirkham. She offered support and explained how he could access additional help if he needed it.
21. We are satisfied that when Mr Kirkham arrived at Altcourse, prison healthcare staff appropriately monitored his existing medical conditions and referred him to relevant specialists to continue his secondary care. They gave immediate support when his cancer recurred and became terminal a few months later.

Mr Kirkham's clinical care

22. On 16 September 2014, the prison's lead nurse for end of life care and Mr Kirkham discussed his condition and planned treatment. She and a healthcare worker and cancer care champion supported Mr Kirkham throughout his illness.
23. Doctors at the Cancer Centre continued to oversee Mr Kirkham's care and healthcare staff offered emotional support after each appointment. On 11 November 2014, the consultant oncologist informed the prison GP that a CT scan had shown little progression of the cancer. As Mr Kirkham had no symptoms, he gave no active treatment, but kept him under observation and repeated the scan on 24 April 2015. On 5 May, he wrote to confirm that the scan had revealed a significant progression of Mr Kirkham's cancer. He prescribed

pazopanib, a new treatment to slow down the growth and relieve the symptoms of cancer and arranged for the medication to be sent to the prison.

24. In between the consultant oncologist's reviews, the prison GP, prison nurses and the palliative care team monitored Mr Kirkham and gave him medication to treat his symptoms and pain. They also gave wing officers a list of symptoms and asked them to contact healthcare staff if he showed any signs of these. Mr Kirkham responded well to the treatment and it slowed down the growth of the nodules. Monitoring continued, with scans every few months. The prison postponed three hospital appointments for security reasons, but the delays were only for a few days and did not adversely affect his treatment.
25. On 8 November 2016, the consultant oncologist informed a prison GP that Mr Kirkham's cancer had spread to his liver and bones. He replaced the pazopanib with palliative radiotherapy, followed by nivolumab, another cancer drug. He thought the drug might allow Mr Kirkham to live for a year or so, but his life expectancy would be much shorter if it was not effective.
26. On 10 November, the healthcare worker and cancer care champion completed a 'preferred priorities for care' document to record Mr Kirkham's wishes and needs. He and prison GPs discussed resuscitation with Mr Kirkham several times. Initially, he wanted staff to attempt resuscitation if his heart or breathing stopped.
27. On 23 November, the healthcare worker and cancer care champion informed a palliative care consultant at the hospital that Mr Kirkham was on end of life care and asked for advice. The same day, a prison GP wrote a prescription for oramorph (liquid morphine) as a contingency if required out of hours. (Additional non-oral medication was later prescribed.) He also arranged for healthcare staff to see Mr Kirkham immediately when he attended healthcare appointments as the holding cell in the waiting area was uncomfortable. Staff created a palliative support care plan on 25 November and an end of life care plan three days later. Both were frequently reviewed and updated.
28. Representatives from the palliative care team, safer custody and probation staff and Mr Kirkham's family liaison officer attended a multidisciplinary meeting on 2 December. There was no formal record of the meeting, but short notes in Mr Kirkham's prison record and the family liaison log indicated that there was discussion about his deteriorating health and future needs.
29. On 7 December, prison staff made a social care referral. It stated that Mr Kirkham had between four and eight months to live, but was coping well. And while he had no immediate social care needs, he was likely to deteriorate shortly.
30. The palliative care consultant visited Mr Kirkham on 19 December and advised a prison GP on his care and adjustments to his medication. She noted Mr Kirkham's frailty and that he was unlikely to tolerate further treatment. On 23 December, the GP again raised the issue of resuscitation, explaining to Mr Kirkham the likelihood that it would be futile and result in poor quality of life. Mr Kirkham then agreed that he did not want to be resuscitated. The GP signed an order to that effect, recording that Mr Kirkham was aware of his prognosis and that he was likely to die shortly.

31. On 30 December, the prison GP advised that a member of staff should sit with Mr Kirkham continuously to monitor and reassure him as he would possibly die within days or even hours. Mr Kirkham died at 12.58am on 1 January 2017 and a locum GP certified his death at 4.15am.
32. The coroner accepted Mr Kirkham's cause of death as metastatic renal cancer (kidney cancer that had spread to other parts of his body).
33. The clinical reviewer concluded that Mr Kirkham's palliative care was well managed, responsive and compassionate. Daily GP reviews and good collaborative working between the healthcare, secondary care and specialist palliative care teams addressed his physical and emotional needs and he was well supported. We are satisfied that, overall, the standard of care Mr Kirkham received was equivalent to that which he could have expected in the community.

Mr Kirkham's location

34. On 12 August 2016, Mr Kirkham refused to be admitted to the prison's inpatient unit for closer observation. A nurse told Mr Kirkham to keep staff informed of his symptoms and that the offer of an inpatient bed remained open. At the request a GP, the lead nurse for end of life care and the manager of Mr Kirkham's residential unit supplied a thicker mattress for his bed. In line with his wishes, Mr Kirkham remained on a normal wing until 14 December, when he was admitted to the prison's inpatient unit. He received visits from friends on his former unit and his family. In the last few days of his life, nurses left Mr Kirkham's cell open overnight so they could check him easily.
35. We are satisfied that staff took account of Mr Kirkham's views about his location and transferred him to the inpatient unit at an appropriate point after his condition deteriorated and they could no longer meet his needs on a wing.

Restraints, security and escorts

36. 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.
37. Mr Kirkham was a category C prisoner. Staff noted that he was well behaved, fully compliant and had been on the enhanced level of the prison's privileges scheme since April 2014. Medical and mobility risk assessments indicated that, although he could move around independently, he walked very slowly. He used a chair for showers because of problems with his balance and he sometimes had difficulty with stairs. On 8 November 2016, Mr Kirkham's consultant informed the prison that he had deteriorated and end of life care began just over two weeks

later. At that time, staff recorded that Mr Kirkham was breathless but preferred to walk to the healthcare centre with the aid of a chair instead of using a wheelchair. On 19 December, his palliative care consultant described him as frail.

38. Mr Kirkham went to hospital over 18 times. Security risk assessments completed in the final months of his illness indicated that he presented a high risk to the public and of violence (due to the nature of his offences); medium risk to family, friends and victims; and low risk on all the other factors, including escape. The medical input largely consisted of 'yes/no' answers about the use of restraints but contained no specific information about Mr Kirkham's health or condition, except annotations that he was 'mobile' and 'fully mobile'. The Head of Security explained that the decisions on the risk assessments were partly based on this information. Escort officers handcuffed Mr Kirkham for hospital visits and were required to seek prior approval from managers to change to an escort chain for treatment. (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.) This continued for appointments up to 11 November, in the latter stages of his disease.
39. The risk assessment for Mr Kirkham's final appointment on 20 December again directed the use of handcuffs. Just before Mr Kirkham and the escorts set off, the Head of Security told staff to remove the restraints due to Mr Kirkham's reduced mobility. We are pleased to note the discretion applied in this instance. However, we are concerned that the risk assessments did not fully reflect Mr Kirkham's weakened condition, as indicated in his medical records and that staff completing the assessments seemed to have attached more weight to the nature of his offences than the risk factors pertaining at the time of the hospital visits. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff completing and authorising risk assessments, justifying the use of restraints on prisoners taken to hospital, understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Kirkham's family

40. On 14 November, a Prison Custody Officer (PCO) introduced himself as Mr Kirkham's family liaison officer. During their discussion, Mr Kirkham said he would tell his family about the severity of his cancer when he felt ready to do so.
41. On 1 December, the PCO arranged a three-way telephone call between Mr Kirkham, his brother and sister. Mr Kirkham told them that his illness was terminal and he had four to eight months to live. The PCO gave Mr Kirkham's family relevant contact numbers and offered regular updates and support. When Mr Kirkham was too unwell to go to the visits hall, his family visited him in the healthcare centre. On 29 December, prison managers agreed that they could visit at any time, without booking in advance.
42. During the morning of 1 January 2017, the Deputy Director and the PCO went to notify Mr Kirkham's sister of his death. As they could not find her house (the door number was incorrect), they telephoned Mr Kirkham's brother, who told them that she was away. They offered condolences and support and arranged to

give him additional information later in the day. A chaplain and other prison staff later telephoned Mr Kirkham's niece and sister. They invited Mr Kirkham's family to a memorial service at the prison on 12 January and gave continuing support.

43. The prison paid the full costs of Mr Kirkham's funeral, which was held on 13 January. The chaplain conducted the funeral service and the PCO attended. We consider that Mr Kirkham's family were well supported by staff at Altcourse throughout his illness and after his death.

Compassionate release

44. 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 prisoners serving indeterminate sentences are set out in Prison Service Order PSO 4700. 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 HM Prison and Probation Service.
45. On 8 November 2016, a prison GP wrote to suggest that, in view of Mr Kirkham's condition and prognosis, the prison should consider compassionate release. (Mr Kirkham's end of life care plan began on 28 November.) Short entries in the preferred care document by the healthcare worker and cancer care champion on 10 November and in the family liaison log after the multidisciplinary meeting on 2 December, noted that Mr Kirkham wanted to move to a hospice near Wrexham and staff would consider release on temporary licence (ROTL). A further line, immediately under the healthcare worker's initial note, stated that Mr Kirkham wanted to stay at Altcourse.
46. On 23 December, an offender supervisor completed section 5 of the application form for consideration of early release. (The remainder of the form was blank.) She noted that although Mr Kirkham's condition had deteriorated, she was unable to assess his risk without a medical report confirming whether his treatment was likely to improve or prolong his life.
47. A prison manager told the investigator that Mr Kirkham was not considered for release while on a residential unit because of his offences and staff considered his health good. She said that on admission to the inpatient unit his life expectancy was around four months, but he deteriorated quickly before they could consider this further and he wanted to stay at Altcourse.
48. Mr Kirkham's views about early release were poorly documented and ambiguous. Staff recorded that he wanted to transfer to a hospice near his home in Wrexham and, conversely in the same entry, that he wanted to remain at Altcourse. His preference was therefore unclear and there is no written record to confirm that he had changed his mind. We are concerned that although prison staff had the opportunity to start an application for early release after the consultant's letter on 8 November, or at the start of Mr Kirkham's end of life care, they did not give this

sufficient priority. Staff did not clearly record his wishes, or give his offender supervisor the necessary medical information to consider the application fully. We make the following recommendation:

The Director should ensure that terminally ill prisoners' preferences about early release on compassionate grounds are clearly recorded; and applications are completed in full and progressed without delay.

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