Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Steel a prisoner at HMP Stafford on 15 February 2017

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.

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 Francis Steel died from cancer of the bile duct on 15 February 2017, while a prisoner at HMP Stafford. He was 87 years old. I offer my condolences to Mr Steel's family and friends.

Mr Steel had several chronic health conditions. Due to advanced dementia, he lacked the mental capacity to understand the implications of the diagnosis of cancer, or communicate his wishes and he was often uncooperative with his treatment and care. In spite of this, I am satisfied that Mr Steel received a high standard of clinical care at Stafford, at least equivalent to that he could have expected in the community.

I am concerned that in the terminal stages of Mr Steel's illness, he was not accommodated in a prison with 24-hour healthcare facilities, given the additional vulnerability resulting from his dementia. I consider that there is a need for healthcare commissioners and HM Prison and Probation Service to improve the clinical pathways for locating terminally ill prisoners appropriately and that referrals for transfer are dealt with promptly.

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 **October 2017**

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Summary

Events

1. Mr Francis Steel was sent to prison on 29 June 2012 and transferred to HMP Stafford in June 2014. He had several chronic health conditions, including dementia and Stafford placed him on palliative end of life care in April 2016.

2. In July 2016, while treating Mr Steel for a bile duct infection, hospital doctors discovered that he had cancer of the common bile duct. As he was unsuitable for surgery or palliative chemotherapy, healthcare staff at Stafford managed his pain and care, in consultation with a palliative care specialist, community agencies and an independent mental capacity advocate. They also arranged for an increased personal care package. Due to Mr Steel's poor and deteriorating mental health, he was not always cooperative with his care and treatment.

3. After his diagnosis, Stafford tried to transfer Mr Steel to a prison with 24-hour healthcare facilities, where it would be easier to manage his considerable physical and mental health needs. However healthcare staff at HMP Birmingham, who are responsible for assessing such prisoners and allocating them to prisons in the area, considered that Mr Steel had no acute clinical needs and that Stafford was providing good care.

4. Mr Steel was admitted to hospital on 29 January 2017, without restraints. During his admission, escort officers occasionally used restraints for short periods when he became physically aggressive. On 6 February, Mr Steel was transferred to a hospice. He died at the hospice on 15 February.

Findings

5. We agree with the clinical reviewer that staff at Stafford worked hard to provide a wide-ranging, supportive and decent standard of clinical care, at least equivalent to that which Mr Steel could have expected in the community. GPs and healthcare staff provided comprehensive and consistent care in challenging circumstances and within the constraints of the facilities available at Stafford.

6. Healthcare staff at Birmingham and Stafford had conflicting views about the need to move Mr Steel to a prison with access to 24-hour healthcare. However, in view of Mr Steel's vulnerability due to his terminal illness, advanced dementia and impaired ability to communicate, we consider that it was inappropriate for him to remain at Stafford. We also consider that Birmingham's handling of the requests to assess him for transfer should have been more timely.

Recommendations

- NHS England and HM Prison and Probation Service should ensure that palliative care policies include clearly defined clinical pathways to locate terminally ill prisoners in accommodation suited to their needs.
- The Director and Head of Healthcare at Birmingham should ensure that referrals to assess terminally ill prisoners for transfer are given appropriate priority and considered without delay.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Stafford 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 Steel's prison and medical records.

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

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

11. An investigation manager wrote to Mr Steel's son, his next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

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

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

Background Information

HM Stafford

14. HMP Stafford is a medium security prison, which holds more than 700 prisoners across seven wings. Care UK has provided healthcare services since April 2016. There are no inpatient facilities. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call GPs outside these hours.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Stafford was in February 2016. Inspectors considered that the range of primary care services was reasonable, with good access to nurses and GPs. Wing-based nurses provided consistent care, treatment and review. However, there were some weaknesses in the provision for older prisoners and those with mental health needs. In particular, there were no healthcare staff with specialist dementia skills, but prison staff took a balanced and reasonable approach to assessing the need for disciplinary action for poor behaviour due to dementia.

16. Inspectors reported that the arrangements to support men with palliative or end of life needs were informed by joint prison and healthcare staff decisions. A palliative care project, with a dedicated specialist nurse, was developing end of life pathways and this had already improved men's experiences.

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 April 2016, the IMB reported that the prison had settled well following its role change from an adult male prison to a sex offender hub. However, the board were concerned that the prison could not always cope with the pressure associated with the health demands of an older prisoner population. Macmillan Cancer Care had funded a full-time project manager in the prison who arranged and monitored end of life care.

Previous deaths at HMP Stafford

18. Mr Steel's death was the ninth from natural causes at Stafford since January 2014. We have previously raised with area NHS Commissioners the issue of accommodating seriously ill prisoners appropriately.

Findings

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

19. Mr Francis Steel was convicted of sexual offences on 29 June 2012 and sentenced to imprisonment for public protection, with a minimum period to serve of six years. He had been in prison before.

20. Mr Steel had angina, high blood pressure, an enlarged prostate and poor memory. He was registered disabled, due to poor mobility and hearing loss in both ears. In prison, he developed several other chronic physical and mental health conditions, including anaemia, an ulcer, gallstones (and subsequently removal of his gall bladder), chronic kidney disease and double incontinence. He was also prone to falls. Hospital specialists managed Mr Steel's conditions and he sometimes spent lengthy periods as an inpatient. In December 2013, he was diagnosed with vascular dementia.

21. After spending time at HMP Dovegate and HMP Birmingham, Mr Steel was transferred to Stafford on 6 June 2014. He became increasingly frail and lost weight. In June 2015, hospital doctors examined his pancreatic and bile ducts and diagnosed a common bile duct stone. As Mr Steel's dementia worsened, his behaviour became challenging and difficult to manage, with physical aggression and inappropriate sexual behaviour to staff and other prisoners. Healthcare staff carried out medical observations five times per hour and care assistants helped with his personal care for four hours per day. Mr Steel often refused to cooperate with treatment in hospital and in the prison. The prison held multidisciplinary case conferences to discuss risk and management plans.

22. On 26 April 2016, due to Mr Steel's complex, deteriorating conditions and poor health, the prison's dedicated Macmillan nurse and project lead began end of life care under the Gold Standards Framework (a national standard for systematic, evidence-based end of life care).

23. Between May and July 2016, Mr Steel was admitted to hospital several times. An MRI scan identified a large gallstone. Mr Steel initially refused further tests and treatment. After he changed his mind, doctors diagnosed cholangitis (infection of the bile duct) and inserted a stent to treat the gallstone obstructing the bile duct. They also carried out blood tests for suspected cancer.

24. On 27 July, a gastrointestinal cancer nurse specialist at the hospital told a prison GP that tests had shown that Mr Steel had cancer of the common bile duct. They both agreed that Mr Steel was unfit for surgery and unsuitable for palliative chemotherapy, due to his poor kidney function. She asked the GP to establish Mr Steel's mental capacity to make decisions about his care and treatment.

25. We are satisfied that healthcare staff monitored Mr Steel's health closely and that routine and emergency referrals to hospital were timely. Specialists had managed his abdominal problems for several years and diagnosed his cancer during tests conducted as part of his ongoing treatment.

Mr Steel's clinical care

26. On 29 July, the prison GP held a 'best interests' meeting with healthcare and mental health nurses. He informed them that although Mr Steel had been told about the diagnosis, he lacked the mental capacity to understand it or the implications and he was unable to communicate his wishes. The same day, he referred Mr Steel to an independent mental capacity advocacy service, confirming that he had no consultable family, as there had been no response when the prison had invited his wife to be involved in decisions about Mr Steel's care.

27. Healthcare and prison staff held frequent multidisciplinary palliative care meetings to discuss Mr Steel's care, including how best to deal with his refusal of treatment. They consulted wing staff, social services, palliative care specialists and other relevant agencies. Their focus was to ensure he was pain free and reduce the risk of falls and pressure sores. On 24 August, a review of Mr Steel's care requirements concluded that his social care visits should increase from three to four per day, so that he could have a final visit at night. (Due to external delays and negotiations about the security implications of night visits, this was not implemented until 12 January 2017.)

28. On 30 September, an independent mental capacity advocate held a meeting with Mr Steel. She also examined his records and had discussions with several people involved in his care, including the prison GP, Macmillan nurse, wing officers, carers and Mr Steel's offender supervisor. She completed a comprehensive report, confirming that she was unable to gain Mr Steel's views about resuscitation and giving detailed advice on options for his daily care.

29. Mr Steel continued to have falls and was frequently incontinent. After consulting the Macmillan nurse and the independent mental capacity advocate, the prison GP signed an order on 24 October, instructing staff not to resuscitate Mr Steel if his heart or breathing stopped. On 4 November, the GP prescribed skin patches for 24-hour pain relief as Mr Steel sometimes refused oral medication.

30. On 9 January 2017, a consultant in palliative medicine at a hospice visited Mr Steel. She said that he could die suddenly at any time, but might live for weeks or months as his body had adapted to his medical problems. She gave advice on appropriate end of life medication. Both doctors agreed that Mr Steel should not receive invasive or intensive treatments unless there would be a significant benefit to his wellbeing.

31. On 29 January, prison carers found Mr Steel unresponsive and paramedics took him to hospital. No restraints were used. The Macmillan nurse visited Mr Steel and kept in close contact with the hospital to obtain updates on his condition and plan for his care on discharge. On 1 February, the hospital prescribed end of life medication.

32. Mr Steel died at 2.18pm, on 15 February, at a hospice. The coroner accepted the cause of his death as cholangiocarcinoma (cancer of the bile duct). Dementia had also contributed to his death.

33. We agree with the clinical reviewer's view that in spite of the limitations at Stafford, the standard of care Mr Steel received was at least equivalent to that which he could have expected in the community. The prison GP provided consistency of care and the palliative care nurse liaised effectively with hospital staff and other agencies.

Mr Steel's location

34. After a mini mental state assessment in 2015, a nurse concluded that Mr Steel was not safe in the prison environment and needed a transfer to long-term secure care. A social worker looked into other accommodation options, but found nothing suitable. Healthcare staff at Stafford tried to arrange a transfer to HMP Birmingham, which had 24-hour healthcare and where Mr Steel had lived before. On 11 April 2016, Birmingham refused the request, as they considered it a social care requirement.

35. On 30 August 2016, staff called paramedics to assess Mr Steel, as he was lethargic and pale, with a headache and abdominal pain. The paramedics said he did not need to go to hospital, but they were concerned that he was locked in his cell overnight for up to 14 hours (typically 6.00pm to 8.00am) and they considered it a safeguarding issue.

36. In October 2016, Stafford's healthcare department made a further referral to Birmingham asking them to assess Mr Steel for transfer. Stafford did not receive an acknowledgement and their attempts to check progress were initially unsuccessful. They re-sent the request on 21 October and 21 November.

37. The deputy Head of Healthcare at Stafford told the investigator that Birmingham held the assessment tool and rota for a group of local prisons, so only their healthcare department could assess Mr Steel for a transfer. She felt it was likely that one of the other prisons would have accepted him if Birmingham could not take him, but Birmingham had completed the assessment. She also explained that Mr Steel was not always cooperative with his treatment and care due to his dementia. While it was better to treat him when he was co-operative, this was not always possible because the domestic carers visited at fixed times, could not return when he was more amenable and there were security issues around providing social care at night. Staff were particularly concerned that he could not receive treatment at night and considered that a 24-hour facility would have had more flexibility to care for him as the need arose.

38. Following correspondence and discussions between the two prisons, Birmingham's healthcare department declined the referral on 30 November, without completing an assessment. A nurse at Birmingham wrote to Stafford explaining that no acute nursing needs had been identified and none of the prisons with 24-hour healthcare could offer nursing care over and above that already in place at Stafford. They also felt that moving Mr Steel to a new location might cause him more distress and that it would be unfair for him to travel a long distance from a new location to attend outpatient clinics in Stafford. She considered staff at Stafford were looking after Mr Steel very well and doing all they could for him, but she suggested they employ a healthcare worker to provide social care at night or increase his existing social care package.

Birmingham's prison managers were aware and supportive of the healthcare department's decisions.

39. After a further approach to Birmingham, healthcare staff agreed to conduct the transfer assessment at Stafford on 25 January 2017. Several people were due to attend, including the Governor of Stafford, a prison GP, the Macmillan project lead, safer custody team and a social worker. Birmingham cancelled the meeting on the morning it was due to take place, without offering Stafford a further date. The Governor wrote to the healthcare managers at both prisons, copied to the healthcare commissioners, expressing his concern about the cancellation and the delays in completing the assessment. He insisted that it should take place quickly, with no further delays or postponements.

40. On 2 February, the Macmillan nurse and the primary care manager at HMP Birmingham went to a multidisciplinary meeting at the hospital. The consensus was that Mr Steel could not return to Stafford because of his deteriorating condition. They agreed that, if he was discharged that day, the primary care manager would find a bed in one of Birmingham's inpatient units, but if delayed beyond this, a fresh referral would be necessary. As Mr Steel developed new symptoms of vomiting during the day, the hospital's palliative care nurse decided to apply for a place at a hospice. Mr Steel moved to the hospice on 6 February, where he remained until his death. Prison staff visited him and telephoned for updates on his condition.

41. In our *Learning Lessons Bulletin* about caring for prisoners with dementia, issued in July 2016, we drew attention to the shortage of appropriate accommodation and facilities for prisoners diagnosed with this condition. We have also highlighted the need to treat terminally ill prisoners in a suitable environment in our thematic report, *Older Prisoners.*

42. Although we acknowledge the significant attempts made by Stafford staff to secure an appropriate location for Mr Steel, we agree with the clinical reviewer that Stafford was an unsuitable location to provide optimum care, given that Mr Steel's dementia complicated the treatment and care needs relating to his cancer. We also have some concerns as to whether the decision-making process at Birmingham in Mr Steel's case was sufficiently robust to mitigate the risks of a real or apparent conflict of interest and we believe that there was an excessive delay in considering the request to assess Mr Steel.

43. We make the following recommendations:

NHS England and HM Prison and Probation Service should ensure that palliative care policies include clearly defined clinical pathways to locate terminally ill prisoners in accommodation suited to their needs.

The Director and Head of Healthcare at Birmingham should ensure that referrals to assess terminally ill prisoners for transfer are given appropriate priority and considered without delay.

Restraints, security and escorts

44. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints.

The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

45. Due to Mr Steel's age, physical and mental health, prison managers told escort staff not to use restraints unless necessary. Occasionally, the escort officers used single handcuffs, or an escort chain, for very short periods when Mr Steel lashed and kicked out at nurses. (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.) They removed the restraints as soon as he became calm and fully documented the length of time and reasons for their use. To preserve Mr Steel's dignity in the days before his death, escort staff wore plain uniform with no belts, chains, or epaulettes.

46. We are satisfied that the prison took a proportionate and humane approach to the use of restraints.

Liaison with Mr Steel's family

47. On 28 July, the day after Mr Steel's terminal illness was diagnosed, the prison appointed a family liaison officer (FLO). On 12 August, she introduced herself to Mr Steel and asked if he wanted her to contact his family, but he did not have the mental capacity to respond to the question. Staff invited Mr Steel's wife and, later, his son to participate in his care planning, but received no reply.

48. Both Mr Steel's wife and daughter, his next of kin, subsequently died and his other children wanted no contact with him. After his wife's death in November, the FLO wrote to other family members, asking if they wanted to be informed if anything happened to Mr Steel. No one responded. The prison tried to telephone Mr Steel's son to notify him of his death and sent a letter by recorded delivery. As they received no response, they asked the police to go to his home. His son's wife told the police officers that they were already aware of Mr Steel's death, as her husband had received the prison's letter.

49. The prison arranged and paid for Mr Steel's funeral, which was held on 1 March. We are satisfied that healthcare and prison staff made every effort to include Mr Steel's family in planning his care and to notify them of his death.

Compassionate release

50. 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.

51. The prison sent an application for early release to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS), now HM Prison and Probation Service, on 17 October 2016. The medical assessment gave no clear prognosis of Mr Steel's life expectancy, but indicated that there was a 50 per cent chance of him surviving six months and 10 per cent that he would survive for a year. The Probation Service stated that Mr Steel required secure 24-hour healthcare and considered that his risks could not

be safely managed in the community. The Governor did not support the application. He considered Mr Steel to be a very high risk of further offending due to recent physical assaults and sexual impropriety towards prison and hospital staff, caused by his dementia.

52. PPCS requested a release and risk management plan. On 24 October, Mr Steel's offender manager began the process to obtain this under the Multi-Agency Public Protection Arrangements, but Mr Steel died before this was completed. We are satisfied that the application for early release was timely.

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