Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Melling a prisoner at HMP Littlehey on 6 November 2018

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 Melling died on 6 November 2018 of oesophageal (food pipe) cancer while a prisoner at HMP Littlehey. He was 68 years old. I offer my condolences to Mr Melling's family and friends.

I am satisfied that the healthcare Mr Melling received at Littlehey was equivalent to that which he could have expected to receive in the community.

I am concerned, however, that decisions to use restraints on Mr Melling when he was taken to hospital between September and October 2018, were clearly unjustified and did not take account of his mobility and serious deteriorating ill-health. I am also concerned that staff failed to get approval from a senior manager on one occasion before using restraints.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. On 23 May 2008, Mr Peter Melling received an indeterminate sentence for public protection (IPP) for sexual offences. He received a minimum term of five years.

2. In 2012, Mr Melling was diagnosed with multiple myeloma (a type of blood cancer). He was in remission and was monitored at quarterly hospital appointments.

3. On 4 July 2017, Mr Melling was transferred to HMP Littlehey.

4. On 10 May 2018, a GP examined Mr Melling as he had lost weight and complained of difficulty swallowing. The GP considered that this might be a sign of oesophageal (food pipe) cancer and made an urgent referral to hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

5. On 11 July, Mr Melling was diagnosed with oesophageal cancer. Between July and October, Mr Melling had two different chemotherapy treatments to try to prolong his life.

6. From 2 November, Mr Melling's health deteriorated rapidly. Staff contacted a hospice daily until a bed became available, and Mr Melling was transferred to the hospice on 5 November.

7. At 9.20pm on 6 November, it was confirmed that Mr Melling had died.

8. The coroner gave the cause of death as oesophageal cancer that had spread to other parts of Mr Melling's body.

Findings

9. Mr Melling was an elderly man, whose health deteriorated rapidly following his diagnosis. His heath needs and risks were assessed and reviewed when necessary, and in a timely manner. The clinical reviewer concluded that the healthcare Mr Melling received at Littlehey was of a high standard and equivalent to that which he could have expected to receive in the community. We agree.

10. The clinical reviewer commended prison and healthcare staff for the compassion and care that they gave to Mr Melling in challenging circumstances.

11. However, the clinical reviewer did find several areas where healthcare practice could be improved.

12. In June 2018, Mr Melling missed an appointment for a scan because there were not sufficient escort staff to escort him to hospital. We are not satisfied that the prison has adequate contingency plans in place to ensure that prisoners do not miss important medical appointments due to staff shortages.

13. Healthcare staff failed to carry out a secondary health screen for Mr Melling which is contrary to NICE clinical guidelines.

14. Mr Melling had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) in place. However, the DNACPR was not always recorded on the escort risk assessment paperwork, which meant that escort staff might not have been aware of it.

15. Shortly before his death, Mr Melling was prescribed anticipatory medicines to help control his pain. Mr Melling was moved to a hospice before these medications were needed. However, we are concerned about the practicalities of nursing staff administering anticipatory medicines in end of life care in a prison without 24-hour healthcare.

16. We are concerned that the risk assessments undertaken by the prison when Mr Melling went to hospital from September to October 2018, did not take account of his physical condition or ability to escape. We do not consider it was appropriate or proportionate to use restraints, given that Mr Melling was increasingly frail due to his advancing cancer. We are also concerned that on one occasion, the use of restraints was not authorised by a senior manager.

Recommendations

- The Governor should ensure that there are sufficient staff and transport available so that prisoners are able to attend hospital appointments.
- The Head of Healthcare should implement secondary reception screening and ensure that it meets the requirements of NICE Clinical Guidance 57: Physical health of people in prison.
- The Head of Healthcare must ensure that healthcare staff record all relevant information on the medical escort risk assessment form, including information about DNACPR orders.
- The Head of Healthcare should develop clear guidance for the care and management of end of life patients outside of healthcare operating hours. The guidance should take into account the skills and capabilities of available staff.
- The Governor must ensure that all escort staff are aware of the procedures for completing an escort risk assessment, in particular that any restraints decision must be authorised either by the Head of Security or by the most senior governor on duty before the escort departs.
- The Governor should provide the Ombudsman with a copy of the prison’s updated escort risk assessment form.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her. A prisoner who knew Mr Melling responded and told the investigator that he considered the care that Mr Melling received from prison staff was of a very high standard.

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

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

20. We informed HM Coroner for Cambridgeshire of the investigation. The coroner gave us the cause of death. No post-mortem was carried out. We have sent the coroner a copy of this report.

21. The investigator wrote to Mr Melling's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He responded but did not raise any concerns.

22. The investigation has assessed the main issues involved in Mr Melling'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.

Background Information

HMP Littlehey

23. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences.

24. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Hospital appointments for prisoners were rarely cancelled. Risk assessments for keeping medications in-possession were not always reviewed and recorded correctly.

Independent Monitoring Board

26. 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 2018, the IMB reported that the prison's working relationship with the local hospice was positive, enabling men to opt for end of life care where they could be surrounded by family and friends. The IMB had concerns about the number of trained Family Liaison Officers being sufficient to deal with the large numbers of deaths in custody. It reported that the End of Life Suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

27. Mr Melling's is the nineteenth death from natural causes at Littlehey in the last two years. This is the third time in the last year we have made a recommendation about the unjustified use of restraints at Littlehey. However, we note that the prison has now revised its escort risk assessment form.

Findings

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

28. On 14 September 2008, Mr Melling received an indeterminate sentence for public protection (IPP, where the court sets a minimum term of imprisonment, after which the offender will be released once they can satisfy the Parole Board that their risk has sufficiently reduced) for sexual offences, with a minimum term of five years. On 4 July 2017, Mr Melling was transferred to HMP Littlehey.

29. When Mr Melling arrived at the prison, a nurse conducted his reception screen. She noted that he had been diagnosed with multiple myeloma in 2012, that he was currently in remission and that he needed to be monitored by a haematology consultant. Mr Melling did not have a secondary reception screen.

30. On 27 July, a GP transferred Mr Melling's ongoing blood cancer care to the Haematology Department at the hospital. Mr Melling was monitored at quarterly outpatient appointments.

31. On 10 May 2018, a prison GP examined Mr Melling because he complained of struggling to swallow for 6-8 weeks, and had lost about 10 kilograms (1 stone 6llb) in weight since January. The prison GP told Mr Melling this might be a sign of food pipe cancer and made an urgent referral to the hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

32. On 22 May, Mr Melling had his first appointment at the hospital's Upper Gastrointestinal Department, which was within the two-week timeframe.

33. On 7 June, Mr Melling attended hospital for an esophagogastroduodenoscopy (an examination via endoscopy of the food pipe, stomach and upper part of the small intestine). The results showed a suspicious lesion in his food pipe. Urgent biopsies and blood samples were taken and an urgent scan was organised. Mr Melling's case was also referred for discussion at the hospital's multi-disciplinary cancer team meeting.

34. Further test results showed that Mr Melling had a high grade malignant tumour (a high grade tumour is one in which the cancer cells may grow and spread very quickly), but he needed a PET (Positron Emission Tomography) scan before a complete diagnosis could be made.

35. On 29 June, Mr Melling was due to attend hospital for the PET scan but there were not enough staff to escort him as a member of staff had not turned up for work. The appointment was cancelled and re-booked for the following week. A Datix incident report form (which is the system used to monitor any problems which might impact on prisoner's medical care) was completed by prison staff. We make the following recommendation:

    The Governor should ensure that there are sufficient staff and transport available so that prisoners are able to attend hospital appointments.

36. On 6 July, Mr Melling attended hospital for the PET scan.

37. On 11 July, Mr Melling was diagnosed with a fast-growing neuroendocrine tumour in his food pipe.

38. On 13 July, a GP and a nurse met with Mr Melling and explained his diagnosis. They told him that the cancer was unlikely to be cured and that the hospital was in the process of putting together a treatment plan. The nurse offered to help Mr Melling explain his diagnosis to his family and she also agreed to inform prison staff on his wing of his diagnosis so that they could support him.

39. On 19 July, Mr Melling attended hospital. He was told that the treatment for his cancer would be palliative, not curative, and that he would have blood transfusion treatments followed by chemotherapy.

40. We are satisfied that healthcare staff appropriately investigated Mr Melling's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr Melling's clinical care

41. On 20 July, Mr Melling told healthcare staff that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made).

42. On 22 July, Mr Melling had his first chemotherapy treatment. He also had regular blood transfusions to treat his symptomatic anaemia.

43. On 19 August, Mr Melling was prescribed oromorph (liquid morphine pain relief), which was kept in a secure cupboard in his cell so he could use it when needed.

44. On 18 September, after two more rounds of chemotherapy, a further scan showed that the tumour had grown and a second tumour was found in a gland above Mr Melling's right kidney. The hospital consultants considered that the treatment was not working and as the tumour was rare, there was no other established form of treatment available to Mr Melling.

45. Staff had frequent conversations with Mr Melling about where he wanted to die (if he was not released from prison). Mr Melling was optimistic that he would live long enough to attend a parole hearing and be released before he died. On 7 October, Mr Melling decided that if he was not released, he would like to go to a hospice. (At the time of his death, Mr Melling was still waiting for a parole hearing date to consider his suitability for release.)

46. On 5 October, the prison started the application process for compassionate release.

47. Mr Melling was given a two weeks break from chemotherapy before starting a different type of chemotherapy-based treatment on 8 October. However, the treatment was stopped because Mr Melling became too ill to tolerate it.

48. Mr Melling's health deteriorated rapidly. Staff contacted the hospice daily to check if a bed was available.

49. On 2 November, Mr Melling was prescribed anticipatory medication in preparation for end of life symptom control, to help relieve pain, breathlessness and anxiety.

50. On 3 November, a pharmacist recorded that nursing staff at the prison had significant concerns about their ability to monitor Mr Melling if any anticipatory medicines needed to be administered outside of healthcare hours. She also recorded that nursing staff were 'unhappy' to give diamorphine (morphine in the form of injections or tablets) to prison staff to administer to Mr Melling as they could not monitor him overnight. As an alternative, extra oramorph was prescribed.

51. Mr Melling's health continued to deteriorate and on 5 November, he was transferred to St John's Hospice.

52. At 9.20pm on 6 November, it was confirmed that Mr Melling had died.

53. We share the clinical reviewer's view that the care Mr Melling received at Littlehey was equivalent to that which he could have expected to receive in the community.

54. However, the clinical reviewer did find some areas where healthcare practice could be improved.

55. PSO 3050, *Continuity of healthcare for prisoners*, says that in the week following the first reception screen, staff should offer a general assessment. Although the second assessments are not standardised, they should be seen as an opportunity for gathering further medical information, checking how the prisoner is settling in, and providing health education in the form of information and health promotion.

56. Mr Melling did not have a second health screen. Although this did not impact on the care Mr Melling received, it should have taken place, and failure to carry out the screenings could be critical to the care of other prisoners in future cases. We make the following recommendation:

The Head of Healthcare should implement secondary reception screening and ensure that it meets the requirements of NICE Clinical Guidance 57: Physical health of people in prison.

57. From July 2018, Mr Melling had a DNACPR order in place. DNACPR orders should be communicated to all relevant staff, including escort staff so that they are aware of the patient's wishes. We are concerned that the DNACPR was only recorded on five out of the 13 escort risk assessments after Mr Melling signed the DNACPR order. If the issue of resuscitation had arisen, prison escort staff would not have been aware of Mr Melling's wishes. We make the following recommendation:

The Head of Healthcare must ensure that healthcare staff record all relevant information on the medical escort risk assessment form, including information relating to DNACPR orders.

58. Mr Melling was prescribed anticipatory pain relief medications for pain control at end of life. HMP Littlehey does not have 24-hour healthcare and nursing staff were concerned that they could not monitor Mr Melling if he took these medications outside of healthcare hours. The prison does not have clear guidelines about the management of anticipatory medications which might lead to better care for the prisoners and would provide reassurance to healthcare and prison staff. We make the following recommendation;

The Head of Healthcare at HMP Littlehey should develop clear guidance for the care and management of end of life patients outside of healthcare operating hours. The guidance should take into account the skills and capabilities of available staff.

Mr Melling's location

59. Mr Melling was initially located on a residential wing where suitable arrangements were made to care for him (such as a heater, microwave and medicine cabinet for controlled pain relief medications). Nurses visited him regularly to ensure his healthcare needs were met.

60. Mr Melling told staff that he wanted to die outside of prison, if not at home then in a hospice. Preparations were made for Mr Melling to go a hospice, and he was transferred to St John's Hospice the day before he died.

61. We are satisfied that Mr Melling was appropriately located throughout his illness.

Restraints, security and escorts

62. 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.

63. After Mr Melling was diagnosed with food pipe cancer in July 2018, he went to hospital 23 times. On 10 September, the escort risk assessment noted that Mr Melling was 'very frail and unwell' and concluded that 'restraints not to be used unless there was a change is circumstances i.e. escape attempt'. Appropriately, Mr Melling was not restrained. Mr Melling attended hospital again on 18 September and he was not restrained due to his ill health.

64. However, on 24 September (six days later), Mr Melling was restrained using an escort chain (which is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The medical section of the escort risk assessment was completed by a nurse, who objected to restraints being used. She recorded that Mr Melling was 'frail and very ill' and that he was

not mobile and used a wheelchair. However, the escort risk assessment was not authorised by a senior manager.

65. The Head of Security told the investigator that once an escort risk assessment is completed, it is passed to an escort officer who is responsible for getting the risk assessment authorised by either the Head of Security or the most senior governor on duty at the time the escort departs. She reviewed the escort risk assessment for 24 September, and said that she could see no reason why the paperwork had not been properly authorised by a senior manager. We make the following recommendation:

    The Governor must ensure that all escort staff are aware of the procedures for completing an escort risk assessment, in particular that any restraints decision must be authorised either the Head of Security, or the most senior governor on duty, before the escort departs.

66. Mr Melling remained in hospital for several days and on 25 September the escort risk assessment was reviewed. The restraints were removed ‘due to Mr Melling’s medical condition’. He remained unrestrained until he returned to prison on 27 September.

67. Mr Melling was restrained using an escort chain on his next three visits to hospital (on 5, 8 and 9 October). The same nurse completed the medical section of the escort risk assessment for each of these visits and she did not raise any medical objections to restraints being used.

68. The nurse told the investigator that she did not object to restraints bring used because she remembered Mr Melling being fit and able, considering his progressive illness, and that he walked to healthcare unaided. She said that she would have used medical records to assess if restraints were necessary, looking for information on whether or not a person was mobile, specifically whether they are in a wheelchair, and refer to the prison’s security cuffing log. This is a document completed by prison security staff, which sets out any conditions that prisoners might have, that would impact on cuffing arrangements. The prison could not provide the investigator with a copy of the cuffing log for October 2018, as records of the log were not kept. However, the Head of Security told the investigator cuffing log records are now being retained by the prison.

69. Although Mr Melling might have been mobile, the medical records said he was ill and frail, and while he might not have been using a wheelchair at that time, he was not as mobile as if he were fit and well. On 7 October, a nurse recorded that Mr Melling was ‘due to start new chemo tomorrow? Is he fit enough?’, and on 9 October, she recorded that Mr Melling was looking ‘pale and frail now’. The clinical reviewer also considered that Mr Melling was likely to have been quite frail at that time.

70. We are concerned that restraints were used on these occasions. We do not consider that this was proportionate to the risks he posed, over and above the control already available through the two escorting officers, given that his health was deteriorating and he eventually became too ill to tolerate the treatment.

71. Appropriately, Mr Melling was not restrained during any other hospital visits or when he was taken to the hospice.

72. In our report on the death of a prisoner at Littlehey in August 2018, we recommended that the Governor ensure 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, and that the Governor should revise the prison's escort risk assessment form to ensure that

- healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
- prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.

73. The prison accepted our recommendation and submitted an action plan in February 2019. The action plan said that the prison had updated the escort risk assessment from January 2019, including a section for healthcare staff to say whether the prisoner's current state of health has an impact on their mobility, and there is a section to demonstrate that this has been considered when assessing the level of risk.

74. We make the following recommendation:

The Governor should provide the Ombudsman with a copy of the prison's updated escort risk assessment form.

Liaison with Mr Melling's family

75. On 8 June 2018, an officer was appointed as the family liaison officer (FLO) and another officer as the deputy FLO. Mr Melling named his brother and sister-in-law as his next of kin.

76. Throughout Mr Melling's illness, the FLOs maintained regular contact with Mr Melling's brother and sister-in-law. They helped arrange family visits and provided updates on Mr Melling's health. When Mr Melling died, the deputy FLO informed the next of kin of Mr Melling's death over the phone as previously agreed with them. (A visit was not possible as they lived almost 200 miles from Littlehey.)

77. Following Mr Melling's death, the FLOs stayed in contact with Mr Melling's brother and sister-in-law to help arrange the funeral and the return of Mr Melling's property.

78. Mr Melling's funeral was held on 5 December, and three representatives from the prison attended. The prison contributed to the funeral costs in line with national policy.

Compassionate release

79. Prisoners can be released from custody on compassionate grounds before their sentence has expired for medical reasons. This is usually when they are

suffering from a terminal illness and have a life expectancy of less than three months.

80. After it was confirmed that Mr Melling would not be offered any further treatment and that his life expectancy was only a few months, staff started the compassionate release application process. Mr Melling's health deteriorated rapidly and he died before the compassionate release application could be completed and considered.

81. We are satisfied that the prison appropriately considered compassionate release.

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