Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Smith a prisoner at HMP Altcourse on 25 November 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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 Wayne Smith died of metastatic cancer of the oesophagus on 25 November 2018, while a prisoner at HMP Altcourse. He was 53 years old. I offer my condolences to Mr Smith's family and friends.

I am satisfied that Mr Smith received a good level of clinical care while at Altcourse, which was equivalent to that which he could have expected to receive in the community.

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 **June 2019**

Contents

Summary

Events

1. On 14 August 2018, Mr Wayne Smith was recalled to HMP Altcourse after failing to comply with his licence conditions. He had a history of paranoid schizophrenia and heroin abuse.

2. While in the community, Mr Smith had been diagnosed with terminal oesophageal (food pipe) cancer and was in the end-stages of his condition.

3. Prison staff and healthcare staff at Altcourse offered appropriate support to Mr Smith. Care plans helped to support his clinical care and ensure he had appropriate resources available to him.

4. On 24 September, Mr Smith was released from prison. He was required to live in supported living accommodation and comply with his licence conditions.

5. On 3 October, Mr Smith was recalled to prison again for breaching his licence conditions. His health had deteriorated and he was admitted to hospital and later to a hospice, for symptom control and pain management.

6. On 7 November, Mr Smith was discharged from the hospice and was sent back to Altcourse. Healthcare staff amended and reimplemented Mr Smith's care plans to ensure he received appropriate care and support.

7. On 24 November, Mr Smith was sent to hospital after vomiting a large amount of blood. His condition continued to deteriorate and on 25 November, it was confirmed that Mr Smith had died.

8. The coroner gave the cause of death as metastatic cancer of the oesophagus.

Findings

9. The clinical reviewer concluded that Mr Smith received a high level of clinical care at Altcourse, which was equivalent to that which he could have expected to receive in the community. We agree. Healthcare staff implemented care plans to ensure Mr Smith received appropriate care, according to his wishes, enabling continuity of care to and from the community.

10. We make no recommendations.

The Investigation Process

11. 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.

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

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

14. We informed HM Coroner for Merseyside, Liverpool district of the investigation. The coroner gave us of the cause of death. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Smith's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

16. The investigation has assessed the main issues involved in Mr Smith'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.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Altcourse

18. HMP Altcourse is a local prison in Liverpool which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,324 sentenced and remanded adult and young adult men. G4S also provides primary healthcare services at the prison. Prime Care provides secondary mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Altcourse was in November 2017. Inspectors noted that the provision of consistent healthcare had been problematic, though recent changes were beginning to improve patient outcomes. The healthcare environment was poor and the waiting area for vulnerable patients was inadequate but there was a clear commitment to health promotion activities.

20. The prison had a range of appropriate and accessible primary care services but prisoners experienced delays in obtaining routine repeat prescriptions. Men with physical health care needs received responsive care but activities and support for men with mental ill health was more limited.

Independent Monitoring Board

21. 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 2018, the IMB reported that a new GP contract had recently been agreed which they hoped would reduce the 8-week waiting time to see a doctor for non-urgent appointments. The IMB highlighted the poor condition of the waiting room for vulnerable prisoners which they described as airless, cramped and generally unfit for purpose.

22. The IMB noted a dramatic reduction in healthcare complaints together with the introduction of a healthcare 'forum,' which gave prisoners the opportunity to raise concerns. The IMB also noted the benefits of health promotion and prevention activity, including stress awareness, HIV, blood pressure, autism, mental health awareness and bowel cancer screening.

Previous deaths at HMP Altcourse

23. Mr Smith was the tenth prisoner to die at HMP Altcourse since November 2016. Seven of the deaths were from natural causes. There were no similarities with those deaths.

Findings

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

24. On 14 August 2018, Mr Wayne Smith was recalled to HMP Altcourse after failing to comply with his licence conditions.

25. During his reception health screen, Mr Smith told healthcare staff that he was at the end stages of oesophageal cancer, which had spread to his lungs and heart. He said that he had been diagnosed while in the community. Healthcare staff promptly obtained Mr Smith's community GP medical records and information from the local hospice, which confirmed Mr Smith's diagnosis and medications. He was referred to the prison GP, who prescribed his medications.

26. Mr Smith was located in the inpatient unit in the healthcare unit to enable staff to provide appropriate on-going care.

Mr Smith's clinical care

27. On 16 August, a nurse conducted a second reception screen. Mr Smith said that he had a Do Not Resuscitate (DNR) order in place, (which meant he did not want anyone to resuscitate him if his heart or breathing stopped). This was confirmed with a prison GP later that day. Healthcare staff implemented care plans to ensure Mr Smith received appropriate care relating to his quality of life and assistance with daily living, which included maintaining a safe environment, communication, eating and drinking, washing and dressing and mobilisation.

28. On 17 August, during a review with a prison GP, Mr Smith said he had a burning pain in his chest and was having breakthrough pain. The prison GP examined him and concluded that he had symptoms of a chest infection. He prescribed an antibiotic and fentanyl patches (a form of opiate based slow release pain relief).

29. Later that evening, a nurse reviewed Mr Smith. He had low blood pressure, was feeling nauseous and had chest pain. An out of hours GP sent Mr Smith to hospital. Mr Smith was discharged from hospital and was sent back to the prison a few hours later with no changes to his current plan of care or medications.

30. On 18 August, a nurse noted in Mr Smith's medical record that a palliative care plan was in place. Healthcare staff were in contact with Mr Smith's community GP and community Macmillan nurses to ensure continuity of care. Healthcare staff were having difficulty communicating with staff at a hospice about Mr Smith's placement because administration staff were reluctant to share information with the prison. As a result, the hospice designated a nurse to liaise directly with prison healthcare staff.

31. Healthcare staff continued to meet Mr Smith's needs. They provided a good level of care, in accordance with his care plans. Staff ensured he was eating and washing and they supported him with his diagnosis.

32. On 28 August, Mr Smith had a mental health assessment with a nurse. Mr Smith said that he was having trouble sleeping. A prison GP prescribed an anti-depressant which helps with insomnia. Mr Smith had lost 2 kilograms (5lb) in

weight so healthcare staff arranged for a soft diet to be provided, including yoghurts and ice-cream to encourage him to eat more and maintain his weight.

33. There was no planned date for Mr Smith to be released. However, on 31 August, a nurse contacted various external services including the community GP, district nurses and the hospice to plan for Mr Smith's release. This was to ensure Mr Smith received continuity of care in the community. Healthcare staff continued to provide care to Mr Smith according to his care plans and needs.

34. On 24 September, Mr Smith was released to a supported living home address. However, on 3 October, Mr Smith breached his licence conditions again and his recall to prison was initiated. He was taken into police custody and was sent to hospital on 4 October.

35. Mr Smith received pain relief and anti-sickness medication via a syringe driver (which allows medication to be administered continuously). He was ready for discharge from hospital, but nursing staff at Altcourse needed to be trained to use syringe drivers, so Mr Smith stayed in hospital.

36. On 15 October, due to a deterioration in his condition, Mr Smith was moved to the hospice for symptom management and pain control. Healthcare staff at the prison liaised daily with staff at the hospice.

37. On 7 November, Mr Smith was discharged from the hospice to Altcourse. He was no longer using a syringe driver and his symptoms were being appropriately managed with medication. Mr Smith's care plans were re-started and he had a comprehensive review with a prison GP and a nurse.

38. On 12 November, Mr Smith told a nurse that his pain was not adequately controlled during the day. As a result, a prison GP increased his fentanyl patch dose.

39. Later that evening, Mr Smith had low blood pressure and reduced responsiveness. A nurse contacted the hospice and the out of hours Palliative Care Team. A doctor from the Palliative Care Team said that Mr Smith should be reviewed by a prison GP in the morning.

40. The next day, a prison GP reviewed Mr Smith. He concluded that Mr Smith's symptoms were likely to be related to his medication and reduced his fentanyl patch dose.

41. In the afternoon, Mr Smith attended a multi-disciplinary team meeting with healthcare staff. He was frail, but he did not want to drink the high calorie supplement drinks he was prescribed. The kitchen staff were given an updated list of soft foods that Mr Smith liked and could tolerate.

42. On 17 November, a nurse had a palliative care review with Mr Smith. He said that his pain was not well controlled. The nurse discussed this with a prison GP who prescribed additional pain relief.

43. On 23 November, Mr Smith's condition deteriorated. He was breathless, agitated and was asking for pain relief. Healthcare staff spent time with him and provided support and reassurance.

44. During the early hours of 24 November, Mr Smith vomited a large amount of blood. He was taken to hospital via emergency ambulance.

45. Mr Smith's condition continued to deteriorate and at 10.00pm on 25 November, it was confirmed that Mr Smith had died.

46. The clinical reviewer concluded that Mr Smith received a good level of clinical care while at Altcourse, equivalent to that which he could have expected to receive in the community. We agree. Mr Smith received a consistently high standard of support, clinical assessment and care. Healthcare staff also planned for Mr Smith's release to ensure continuity of care in the community, and is evidence of good practice.

Mr Smith's location

47. Mr Smith was appropriately located in the inpatient unit in the healthcare unit at the prison until he was released on 24 September.

48. When Mr Smith was recalled on 3 October, he was sent to hospital as an inpatient. He was then moved to a local hospice for symptom control on 15 October.

49. Mr Smith returned to Altcourse inpatient unit on 7 November, until he was taken to hospital on 24 November.

50. We are satisfied that prison staff and healthcare staff considered Mr Smith's wishes and needs. His location was appropriate at all times.

Restraints, security and escorts

51. 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.

52. No restraints were used for any of Mr Smith's external appointments or admissions to hospital and the hospice. This was appropriate and evidence of good practice.

Liaison with Mr Smith's next of kin

53. The prison appointed a prison manager as the prison family liaison officer. Mr Smith named his brother as his next of kin, who was already aware of Mr Smith's diagnosis. Mr Smith's brother visited him in the hospice. The prison manager supported Mr Smith to maintain telephone contact with his brother.

54. On 25 November, the prison manager telephoned Mr Smith's brother, as previously agreed, to inform him of Mr Smith's death. The prison manager explained the on-going coronial process and provided on-going support.

55. On 28 November, Mr Smith's brother asked the prison manager to keep the manager of Mr Smith's supported living home informed of the funeral arrangements.

56. On 6 December, Mr Smith's brother informed the prison manager that he was no longer taking responsibility for the on-going funeral arrangements and was handing over responsibility to the manager of the supported living home.

57. Mr Smith's funeral was held on 20 December. The prison contributed to the cost of the funeral in line with national guidance.

58. The prison manager offered on-going support to Mr Smith's brother and the manager of the supported living home.

Compassionate release

59. 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.

60. Because Mr Smith continued to breach his licence conditions in the community he was not assessed as suitable for early release.

61. We are satisfied that the issue of compassionate release was considered.

62. We make no recommendations.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141