Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Clarke, a prisoner at HMP Hindley, on 17 November 2016

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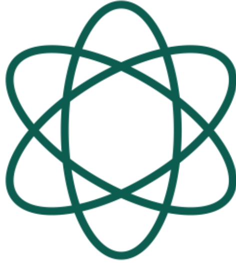
Our vision

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 Mark Clarke died of cancer at hospital on 17 November 2016, while a prisoner at HMP Hindley. He was 54 years old. I offer my condolences to Mr Clarke's family and friends.

Mr Clarke had been in prison since 2014 but had relatively infrequent contact with healthcare services. Healthcare staff appropriately referred Mr Clarke to specialists for further investigation when he presented with concerning symptoms. His condition deteriorated quickly and he died before he could be considered for compassionate release, or transferred to a hospice for palliative care.

I am satisfied that Mr Clarke received a good standard of care in prison, at least equivalent to that 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2017**

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Summary

Events

1. On 11 August 2014, Mr Mark Clarke received a six-year prison sentence for drug-related offences.

2. Mr Clarke was sent to HMP Humber where he had limited contact with healthcare services, receiving infrequent treatment for minor health problems.

3. On 15 August 2016, a prison GP referred Mr Clarke for a chest X-ray after he reported having chest pain and coughing up blood. Mr Clarke transferred to HMP & YOI Hindley ten days later, and went to hospital for the X-ray on 25 August. The results of the X-ray were abnormal, and the specialist referred Mr Clarke for a follow up scan in four to six weeks.

4. On 16 October, Mr Clarke has a follow up X-ray which was again abnormal. A prison GP referred Mr Clarke for support from a lung cancer multidisciplinary team because he suspected Mr Clarke had cancer.

5. Over the following weeks, Mr Clarke experienced intermittent chest pain, and was admitted to hospital on 12 November when his health deteriorated further. In hospital, Mr Clarke suffered a chest infection and had difficulty breathing.

6. Hospital doctors formally diagnosed Mr Clarke with advanced lung cancer on 15 November, with a prognosis of 50 – 60 days to live. However, Mr Clarke’s condition rapidly deteriorated and he died later that day.

Findings

7. The clinical reviewer found that healthcare staff appropriately referred Mr Clarke for further investigation at hospital when he presented with concerning symptoms and involved specialist services in his care. They also provided good support to Mr Clarke and involved him in discussion about his care. It appears Mr Clarke’s cancer was already advanced and had spread, and he died much sooner than anticipated.

8. We are satisfied that Mr Clarke received a good standard of care in prison, at least equivalent to that he could have expected to receive in the community. We make no recommendations.

The Investigation Process

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

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

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

12. We informed HM Coroner for Greater Manchester West District of the investigation, who gave us the cause of death. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers wrote to Mr Clarke's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Clarke's family asked whether Mr Clarke's cancer was diagnosed at the earliest opportunity.

14. The investigation has assessed the main issues involved in Mr Clarke's care, including his diagnosis and treatment, whether appropriate clinical care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

15. The initial report was shared with the Prison Service. They have not detailed any factual inaccuracies. We are disappointed they have not responded in time.

16. Mr Clarke's family received a copy of the initial report. The solicitor representing Mr Clarke's family wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP & YOI Hindley

17. HMP & YOI Hindley is a medium security prison which can hold up to 664 adult males and young offenders on seven residential wings. The two populations are housed separately, although they mix during daily activities.

18. Bridgewater Community Healthcare NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundations Trust provide health services at the prison. The healthcare centre has outpatient facilities. Nursing staff are on site 24 hours a day and GP's provide daily clinics as well as weekend and out-of-hours support.

HM Inspectorate of Prisons

19. The most recent inspection of Hindley was in July 2016. Inspectors reported that health services were reasonably good, although nurse shortages affected primary care services and there were problems with administering medicines on time. Inspectors found that prisoners had a positive view of the service provided by GPs in managing lifelong conditions and medication reviews.

Independent Monitoring Board

20. 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 2015, the IMB reported that they had received few complaints about health care provision, despite the challenges faced in treating older prisoners with complex health problems. GP clinics were very adequate, and the waiting time to see a GP compared favourably with expectations in the community.

Previous deaths at HMP & YOI Hindley

21. Mr Clarke was the third prisoner to die at Hindley since the January 2016, and the first from natural causes. There were no significant similarities between the circumstances of Mr Clarke's death and previous deaths at the prison.

Findings

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

22. On 20 August 2014, Mr Mark Clarke arrived at HMP Humber after receiving a six-year sentence for drug-related offences. He had been in prison before.

23. At an initial health screen, healthcare staff recorded that Mr Clarke had a history of cocaine and cannabis abuse. They also noted that he was a moderate smoker of cigarettes and offered him smoking cessation advice, which he refused (Mr Clarke was offered cessation advice again while in custody, but always refused it). Mr Clarke had limited contact with healthcare services after this, receiving infrequent treatment for irritable bowel syndrome, gastritis (stomach inflammation) and headaches.

24. On three occasions in late 2015 and early 2016, healthcare staff suspected that Mr Clarke had used a new psychoactive substance (NPS, an illegal synthetic drug) after he reported feeling unwell, suffering from chest pains and high blood pressure. On 13 April 2016, following a hospital admission for chest pain, Mr Clarke told healthcare staff that he had smoked 'Spice', an NPS.

25. On 15 August 2016, a prison GP reviewed Mr Clarke after he reported having had right-sided chest pain for 10 days. Mr Clarke also said that he had been coughing up blood. He examined Mr Clarke's chest, which was clear. He prescribed antibiotics for Mr Clarke's chest pain, and referred him for a chest X-ray because of his symptoms and medical history.

26. On 23 August, Mr Clarke transferred to HMP & YOI Hindley. At an initial health screen, healthcare staff recorded that Mr Clarke displayed no chest pain or difficulty breathing. A prison GP reviewed Mr Clarke on 24 August. He recorded that Mr Clarke's symptoms had improved after taking antibiotics, and he had not experienced any weight loss. He noted that Mr Clarke was still waiting for a chest X-ray and said that he would review the results.

27. Mr Clarke went to the hospital for a chest X-ray the following day. Healthcare staff received the results on 2 September. The radiologist reported a prominent right hilum (the section in the central area of the lung that allows structures to enter and exit). They said that the abnormal result might be due to a slight rotation during the X-ray. However, because of Mr Clarke's clinical history, the radiologist recommended another X-ray in four to six weeks.

28. Over the following weeks, Mr Clarke experienced intermittent chest pain. Healthcare staff prescribed him amoxicillin (an antibiotic). They also ordered an echocardiogram (ECG – tests the electrical rhythm of the heart), which showed no significant concerns.

29. Mr Clarke returned to hospital for another chest X-ray on 16 October. Healthcare staff received the results the following day, which showed extensive shadowing within the right lung and a slightly enlarged hilum. The radiologist suggested treating Mr Clarke for a chest infection, although noted that the results were not entirely typical of an infection.

30. After reviewing the X-ray results, a prison GP referred Mr Clarke for a lung cancer multidisciplinary team (MDT) review regarding treatment). On 18 October, the MDT coordinator confirmed that the hospital would write to healthcare staff with Mr Clarke's proposed plan of care. They advised that Mr Clarke should attend hospital on 2 November for a chest computed tomography scan (CT scan, an enhanced X-ray scan).

31. A prison GP assessed Mr Clarke on 24 October and diagnosed lung consolidation (swelling or hardening of normally soft tissue). He ordered blood tests, which were normal. He decided to review Mr Clarke again in two weeks, and recorded that Mr Clarke was happy with this plan.

32. The prison cancelled Mr Clarke's hospital appointment on 2 November after he threatened a prison officer who was escorting him. Mr Clarke attended a re-arranged appointment on 7 November.

33. On 10 November, the prison GP reviewed Mr Clarke again when his condition suddenly deteriorated. He recorded that Mr Clarke had difficulty breathing and poor medical observations. He decided to send Mr Clarke to hospital for treatment. A respiratory consultant told Mr Clarke he had symptoms of Chronic Obstructive Pulmonary Disease (COPD - lung disease), and prescribed Mr Clarke a ventolin inhaler to help him breathe. The consultant also told Mr Clarke that the results of the CT scan from 7 November showed that he may have lung cancer.

34. Another respiratory consultant reviewed Mr Clarke in hospital on 11 November. The consultant explained the potential diagnosis and arranged for Mr Clarke to attend the hospital as an outpatient on 14 November for further investigation. When Mr Clarke returned to prison, a GP prescribed him pain-relieving drugs, and nutritional drinks to help with his diet.

35. On 12 November, Mr Clarke reported increasing back pain and was generally unwell. Healthcare staff treated Mr Clarke in his cell during the night as his condition deteriorated. The out of hours doctor recommended that Mr Clarke should be transferred to hospital for further assessment, and Mr Clarke was admitted to hospital later that day.

36. Mr Clarke remained in hospital for further assessment and treatment. On 15 November, hospital doctors confirmed that Mr Clarke had been diagnosed with advanced lung cancer, with a prognosis of around 50 to 60 days.

37. The clinical reviewer concluded that prison healthcare staff appropriately managed Mr Clarke's symptoms. When Mr Clarke first presented with chest pain and a productive cough, the prison GP referred Mr Clarke for a chest X-ray, in line with National Institute for Health and Care Excellence (NICE) guidelines to assess for lung cancer in people aged over 40 with a history of smoking and chest pain. Healthcare staff also followed NICE guidelines in referring Mr Clarke to the MDT for further assessment when they suspected he had lung cancer.

38. We are satisfied that prison healthcare staff acted promptly and appropriately in arranging the investigations which led to Mr Clarke's diagnosis.

Mr Clarke’s clinical care

39. After his provisional diagnosis on 10 November, healthcare staff and hospital doctors monitored Mr Clarke and discussed his care with him. When Mr Clarke returned to prison, a GP prescribed him co-codamol and zopiclone to relieve pain, and nutritional drinks to support his diet.

40. Following Mr Clarke’s admission to hospital on 12 November, healthcare staff had frequent contact with the professionals treating him in hospital. Nurses and prison GPs visited Mr Clarke on the ward to provide support and discuss his wishes for future treatment.

41. A respiratory consultant planned to meet Mr Clarke and his family on 18 November to discuss the results of further medical investigations and Mr Clarke’s plan of care. However, his condition deteriorated further. Mr Clarke suffered from a chest infection and had oxygen therapy to help him breathe.

42. On 17 November, a prison GP met Mr Clarke in hospital to discuss his confirmed cancer diagnosis. He recorded that Mr Clarke was frail and slightly confused, but understood the diagnosis. Mr Clarke had agreed with hospital doctors that they would not resuscitate him if his heart or breathing stopped. He spent time with Mr Clarke discussing his prognosis and plans for future care. A consultant confirmed that the cancer could not be treated, and would be managed palliatively.

43. At around 4.00pm, Mr Clarke’s health deteriorated further. Hospital doctors started an end of life care plan and gave Mr Clarke diamorphine (an opiate painkiller) for pain relief. Mr Clarke became unconscious, and he died at around 9.50pm. His family were with him when he died.

44. Following his admission to hospital, Mr Clarke’s treatment was the responsibility of secondary services at the hospital. However, the clinical reviewer found that healthcare staff at the prison closely monitored Mr Clarke’s condition, identified problems when indicated and referred him to specialists when this was necessary. They concluded that his care was equivalent to that which he would have expected to receive in the community. Healthcare staff supported Mr Clarke when he was told he was likely to be suffering from cancer, and continued to provide support when he was in hospital.

45. We are satisfied that Mr Clarke received satisfactory care for his suspected cancer in prison, and that healthcare staff appropriately referred him for hospital assessment and treatment as required.

Mr Clarke’s location

46. Mr Clarke lived on a residential wing at the prison. Although the prison healthcare unit does not have an inpatient facility, nursing staff provided good support to Mr Clarke on the wing when he needed assistance with pain relief and medication. When it became clear that Mr Clarke’s health needs could not be managed at the prison and he required acute care, he was quickly admitted to hospital.

47. On 17 November, Mr Clarke and a prison GP discussed Mr Clarke’s preferred location for end of life care. Mr Clarke said that he would like to move to a hospice

near to his family in Liverpool. However, Mr Clarke's condition deteriorated suddenly and he died later that day.

48. While it is unfortunate that there was not time to transfer Mr Clarke to a hospice for palliative care, we are satisfied that staff appropriately considered Mr Clarke's location during his illness.

Restraints, security and escorts

49. 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.

50. When Mr Clarke initially went to hospital for assessment, officers used handcuffs, which were removed for treatment. The risk assessments included appropriate input from security and healthcare staff. On 15 November, when Mr Clarke's condition deteriorated, prison managers decided that he should no longer be restrained, and officers did not use handcuffs again. We are satisfied that the prison took a proportionate and humane approach to the use of restraints.

Liaison with Mr Clarke's family

51. On 11 November, a nurse spoke to Mr Clarke about informing his family of his potential diagnosis. With Mr Clarke's agreement, she spoke to Mr Clarke's daughter, his nominated next of kin, to explain his condition. She also gave details of Mr Clarke's future hospital appointments.

52. When Mr Clarke was admitted to hospital, members of his family visited him on the ward. As Mr Clarke neared the end of this life, prison and healthcare staff attended the hospital to provide support for Mr Clarke's family.

53. Following Mr Clarke's death, the Governor contacted Mr Clarke's family to offer his condolences. The prison appointed an operational manager as a family liaison officer. He stayed in contact with Mr Clarke's family and offered condolences and support. Mr Clarke's funeral was on 14 December. The prison contributed to the costs in line with national policy, but staff did not attend at the request of Mr Clarke's family. We are satisfied that there was appropriate family liaison.

Compassionate release

54. 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.

55. Release on temporary licence (ROTL) can also be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present

unacceptable risks. The governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

56. On 15 November, an operational manager approved ROTL for Mr Clarke, so he could access cancer treatment outside prison. On 17 November, when it became clear that Mr Clarke was nearing the end of his life and treatment was not an option, a prison GP spoke to prison managers about starting the process for compassionate release. However, Mr Clarke's condition deteriorated very quickly and he died much sooner than expected. We are satisfied that the prison appropriately considered compassionate release on behalf of Mr Clarke.

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