Investigation into the circumstances surrounding the death of a man in a hospice on 2 January 2008, having been released from HMP Swaleside on 22 December 2007

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

This is the report of an investigation into the circumstances of the death of a man on 2 January 2008 at a hospice. The man had been released on compassionate grounds from HMP Swaleside on 22 December 2007.

As the man was no longer a serving prisoner, no post mortem examination took place after his death. The clinical review states that he died of natural causes namely an aggressive cancer in his throat and neck which progressed rapidly despite treatment.

My colleagues and I would like to extend our condolences to the man's partner, his family and all those touched by his death.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the man's medical care in prison was commissioned from the Eastern & Coastal Kent Primary Care Trust, and was carried out by an independent doctor. I am grateful for their assistance. I would also like to thank the management and staff at HMP Swaleside for their co-operation during the course of this investigation.

The man's health was compromised on reception into prison in 2006. In June 2007, he was diagnosed with cancer in his throat and neck. He received chemotherapy, radiotherapy and support for the difficulties he experienced associated with his medical conditions and the side effects of his treatments. His condition deteriorated over a number of months and it became clear that he was unlikely to survive. The man who died was released from prison on compassionate grounds. He was offered and took up a place at a hospice in late December 2007. He died there 12 days later.

It is clear that the man received timely and appropriate medical care and had exceptional support throughout his time in Swaleside. His death could not have been prevented. The clinical reviewer finds that the latter stages of the man's illness were miserable and distressing. Despite that sombre context, I am immensely encouraged by the quality and humanity of the care the man received at Swaleside. I reproduce in full the uplifting paragraph at the conclusion of the doctor's clinical review, "The medical and nursing care he received following his diagnosis were exemplary and certainly comparable with anything he might have received had he been based in the community. This rare, complex, and distressing malignancy was managed by all concerned with compassion and professionalism."

Jane Webb
Deputy Prisons and Probation Ombudsman **November 2008**

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SUMMARY

The man who died was a prisoner at HMP Swaleside and died of cancer on 2 January 2008 at a hospice. He was 45 years old and had been released from custody on 22 December 2007 on compassionate grounds. The man was serving a life sentence imposed in 2006 for grievous bodily harm, with a minimum term of six years imprisonment. The sentence was later varied on appeal; the minimum term to serve was reduced to five years.

The man's health was compromised by HIV and Hepatitis C and he also smoked. Prior to imprisonment his health and treatment were monitored by a specialist clinic. This arrangement continued after he was received into prison and whilst he was still located in London.

In June 2007, the man was transferred to Swaleside and soon after was diagnosed with an invasive throat cancer for which he underwent chemotherapy and radiotherapy, necessitating frequent visits and admissions to local hospitals.

In July 2007, the man was admitted to Swaleside Healthcare Centre to facilitate the implementation of a complex care plan and to support him through an extended and uncomfortable period of treatment. He was also referred to a hospice for support, principally in the form of a Macmillan Nurse and under the supervision of a hospice doctor.

By early September the man's illness was regarded by the healthcare professionals as terminal and the prison medical officer started the procedure for release on compassionate grounds. By mid September a percutaneous endoscopic gastrostomy (PEG) feeding tube insertion was planned to support his nutritional and medicinal intake. The man initially refused his consent for the operation because he was apprehensive about the procedure.

The man's health predictably deteriorated and he was admitted on several occasions to outside hospitals. In early October, he consented to having the PEG feeding tube inserted and the operation took place on 10 October. During this time complications developed and the man's health continued to deteriorate. The PEG feeding tube was removed because of infection and was replaced at another site some weeks later.

On 2 November, the Parole Board approved an application for the man's release on compassionate grounds. The licence conditions included residence in hospice accommodation approved for the delivery of terminal care. On 5 November whilst at outside hospital, the man began refusing medication and his prognosis was poor. The following day, because of the severity of his medical condition, a note that he was not to be resuscitated (DNR) was made by doctors.

Following further discharges and re-admissions to hospital the man returned to Swaleside on 18 December. His physical condition had further deteriorated and his nursing care became much more intensive. The hospice doctor visited the man at Swaleside on 21 December and offered him admission to the hospice. At this point the man realised the seriousness of his situation and accepted the offer. A note

written on the original DNR document was countersigned by the doctor confirming the decision.

The Parole Board's decision to release the man on compassionate grounds was received at Swaleside on 21 December. The man was admitted to the hospice on 22 December where he remained until his death on 2 January 2008.

A memorial service took place on 15 January which was attended by the man's family, friends and staff from Swaleside.

I commend two members of Swaleside staff and make no other recommendations.

The man's partner and sister responded to the draft and commented that they were pleased with the report and thought it was a very accurate record of events. They again spoke positively about Swaleside and how helpful prison staff had been both before and after his death.

The Prison Service in response to the draft report said that, "It is encouraging to receive such a positive report on Swaleside and Healthcare in particular." The Governor at Swaleside also noted my commendation and is considering how best to recognise the compassion and professionalism exhibited by the two members of staff.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Swaleside on 16 January 2008. He was given a full briefing about the circumstances surrounding the man's death by the Governor. The investigator also met a representative of the Prison Officers' Association but was unable to speak to a member of the Independent Monitoring Board.

2. Invitations were extended to staff and prisoners, inviting anyone who might have information relating to the man who died to make themselves known to the investigator. One prisoner took up the invitation. The investigator also met relevant prison staff, principally members of the healthcare department. There was no police involvement in the investigation of the man's death.

3. One of my Family Liaison Officers (FLO) spoke to the man's partner and on 30 January 2008 wrote to her. Shortly afterwards she, on 11 February, and the man's sister, on 1 March, wrote letters to the FLO commending the care the man received at Swaleside and highlighting their concerns about the treatment he received in outside hospital. The FLO explained to them that an independent clinical review commissioned by the Ombudsman would consider the appropriateness of the healthcare the man who died received whilst in prison. The FLO also explained that the investigation could not consider any healthcare he received in an outside hospital that being outside the Ombudsman's remit. The FLO advised that consideration be given by the family to contacting the Parliamentary and Health Service Ombudsman for whom she provided contact details.

4. Swaleside provided copies of the man's prison and medical records. The Eastern and Coastal Kent Primary Health Trust (PCT), was commissioned to provide a clinical review and an independent doctor was appointed to undertake the review.

5. The Coroner's Officer was contacted on 8 January and informed the PPO investigator that the man had died after being released from custody on compassionate grounds. A post mortem had not taken place and an inquest is not planned.

HMP SWALESIDE

6. HMP Swaleside is a category B training prison built in the late 1980's. It holds sentenced adult male prisoners serving over 4 years in cellular accommodation. It has an operational capacity of 778 of whom 460 are life sentence prisoners in the first and second stages of their sentence.

7. Healthcare at Swaleside is provided by the Eastern & Coastal Kent Primary Care Trust. Daily medical services are provided by a Primary Care Physician and three nursing staff. At night there is one qualified nurse on duty with access to a doctor through the local Medoc service. The clinical staff are all appropriately qualified. Sudden illnesses and treatments are managed by appropriately qualified clinical staff.

8. HM Chief Inspector of Prisons (HMCIP) made an unannounced full inspection of Swaleside in January 2006. She highlighted in her report, and which are of relevance to this investigation, that:

    - Healthcare staffing levels were low and only one member of healthcare staff was on duty at night. HMCIP recommended that there should be at least two members of healthcare staff on duty at night.
    - Documentation was poor in most of the clinical records sampled. Healthcare staff had, in the past, been criticised by the Prison and Probation Ombudsman for poor records and lack of contemporaneous note-keeping. HMCIP found little evidence of any improvement. HMCIP recommended that all clinical records should be contemporaneous, factual, consistent and accurate. They should provide clear evidence of planned care and decisions made. She also recommended that healthcare staff should abide by the Nursing and Midwifery Council guidelines for records and record keeping.

9. There have been four deaths in custody at Swaleside since June 2004, three of which were from natural causes with the other being self inflicted. A recommendation made in the Prisons and Probation Ombudsman's report following a death in custody in July 2006 from natural causes says that:

    - The recording of accurate, detailed and contemporaneous notes is mandatory. Healthcare staff must ensure that all entries on a prisoner's medical notes adhere to a standard of professional competence and expertise.

    Swaleside responded accepting the recommendation and took action to ensure staff signed to state that they are aware of their professional clinical responsibility for accurate record keeping in line with the guidelines of the Nursing and Midwifery Council and the General Medical Council.

KEY EVENTS LEADING UP TO 2 JANUARY 2008

10. The man who died was arrested on 29 November 2005. On his police custody record he is recorded as having seen a doctor twice, firstly during the afternoon for a head injury. The second time, later that day, was after being interviewed regarding his medical care. He was recorded as suffering from HIV, Hepatitis C and asthma and to have had a chest infection. He was also recorded as receiving a "combination of meds" and in "numerous amounts" and the doctor notes during the interview "no medication for HIV at present". A pre sentence report by a probation officer indicates that he was not taking medication because of his domestic circumstances. He was noted by a doctor as fit to be detained.

11. The man was remanded into custody at HMP Pentonville on 30 November for an offence of Grievous Bodily Harm. During his first night interview he said that he had cut his arm with a piece of plastic some four years previously whilst at Pentonville, but no current indications were noted that he might harm himself at that time. His cell sharing assessment indicated that he was not thought to be at risk of self harm and he was regarded as suitable to share a cell.

12. On 1 December, the man who died was interviewed in the course of the secondary health assessment process. He confirmed his partner as his next of kin and told staff that he was taking Dihydrocodeine (an analgesic for moderate to severe pain) for problems with his legs and hands and Ranitidine (to reduce the amount of stomach acid produced) for an ulcer. The man confirmed his HIV and Hepatitis C status and also said that he suffered from asthma, anxiety and depression, had regular monthly appointments at hospital and needed a high protein diet. Medical staff at Pentonville confirmed with the man's supervising doctor at North Middlesex University Hospital (NMH) that the man was HIV positive and was taking Salbutamol for his asthma, Ensure, a nutritional supplement and DF118 (Dihydrocodeine) for peripheral nerve damage. The man was seen by the prison medical officer on 2 December.

13. The man's supervising doctor at NMH wrote a letter, dated 6 December, explaining that the man who died had initially presented with HIV in April 1999 and that he was also Hepatitis C positive which together resulted in recurrent skin and chest problems. He added that the man suffered from chronic anxiety, stress and depression, chronic asthma and neuropathy. The supervising doctor also wrote that the man was taking Dihydrocodeine 30mg and Ranitidine 150mg, both twice daily. On 16 December, the Prescription and Administration Chart shows that Dihydrocodeine 30mg was prescribed for him twice daily for seven days. He received that dosage until 19 December when he attended court.

14. On 19 December, the man was sentenced to 12 months' imprisonment for a separate offence, with an extended licence period of two years. Following this court appearance he was taken to HMP Wormwood Scrubs. The sentence was subsequently varied on appeal. His cell sharing assessment shows that he was regarded as a medium risk of harm to others and no concerns were raised with regard to self harm.

15. The man was seen on 20 December following his transfer from Pentonville and his medical status was noted. He was prescribed Ventolin and Becotide for his asthma and Ranitidine for his ulcer. His Salbutamol inhaler proved ineffective but Ventolin and Atrovent nebulisers controlled his symptoms and, over the following seven weeks, according to the Prescription and Administration Chart, he was given them up to three times daily. On 29 December, he was prescribed Ensure plus, a nutritional supplement, and a Ventolin inhaler was given to him in possession. He also spoke to medical staff about re-starting combination therapy. He was experiencing pain and requested that his analgesia be reviewed. On the following day, the man was seen regarding the combination therapy and again requested Dihydrocodeine and refused paracetamol.

16. On 3 January 2006, (although the date is noted incorrectly as 3 December 2005), a note in the Continuous Clinical Record timed at 3:10pm indicates that the man requested a doctor's appointment and complained of pain in his legs, hands, abdomen and back. He saw the prison doctor the same day and asked for Dihydrocodeine which he had received at Pentonville. The man refused to sign a request for medical information form, became angry and stated that he would refuse all treatment. Some 40 minutes later he decided to restart his nebuliser medication. The consultation note contains the entry "see entry of 01/12/05 doctor got confirmation from GP but didn't write that he has prescribed DF118 bd".

17. The Continuous Clinical Record shows that on 10 January a Staff Nurse attended the man's cell after he had reportedly collapsed. When the nurse arrived he was alert and communicative and indicated that he had pain in his right side. He refused the offered analgesia and requested Dihydrocodeine, which was refused on the grounds that only a doctor could prescribe that particular drug.

18. During a consultation on 11 January the Senior Medical Officer examined the man's abdomen after he complained of a lump and pain. He wrote that the man had two small lumps on the right upper quadrant of his liver and that he was demanding DF118 which was not prescribed. He was offered a small dose of amitriptyline, an antidepressant, and a referral to the detoxification unit, both of which the man refused. He was however prescribed Nystatin for oral thrush and was referred to the Genitourinary Medicine Clinic (GUM) clinic. He again refused to sign the form which would enable staff to contact his doctor in order to obtain further medical information and left the consultation room in an angry mood. The following day a prison doctor saw the man in the GUM clinic and noted that he would contact the man's supervising doctor at the NMH.

19. On 12 January, the man made a formal complaint about his examination and treatment by the Senior Medical Officer. The Healthcare Principal Officer (HCPO) responded on 27 January. A note dated 13 January by the HCPO indicates that the man continued to complain that he was not being prescribed the correct medication. Staff at Pentonville could not locate medication charts but were able to provide sufficient proof of the type and quantity of medication that had been previously prescribed. This information was passed to the wing surgery with the result that Dihydrocodeine was prescribed twice daily for 28 days and a repeat prescription for Ranitidine was issued.

20. By 19 January, the man who died was complaining of night sweats and arrangements were made to exchange his bedding. The following day he had the first of a course of three Hepatitis B vaccines. He also made a formal complaint about his analgesic medication to which the HCPO responded on 26 January. Dihydrocodeine was re prescribed for 28 days but the Prescription Chart does not record it being administered.

21. On 8 February, the man was remanded for trial at a Crown Court in London for an offence of GBH and was returned to Pentonville.

22. Because of a worsening of his asthma and the possibility of pneumocystis (a form of pneumonia) the man was referred for a chest x-ray on 17 February and treatment for a chest infection was given in consultation with his HIV specialist. The x-ray took place on 27 February and the results showed nothing of note. His treatment for asthma and other medical conditions continued and he had regular consultations with medical staff.

23. The man who died appeared at the Appeal Court on 21 March where the sentence he was currently serving was varied to 12 months imprisonment and the extended licence was quashed.

24. At a medical consultation on 27 March blood was taken to monitor the man's progress. A note on his Continuous Clinical Record indicates he felt that his liver was enlarged and that his left lower chest was "playing up". On examination, his chest was clear and his liver was neither enlarged nor tender. However it was noted that subcutaneous lumps were appearing and growing on his body and limbs and had been doing so for a few months. The examiner wrote that the man was due to see his supervising doctor at the NMH in the near future. A further note dated 31 March indicates there had been a substantial weight loss and that the man should be booked in to the A wing clinic. A "semi-urgent" referral to HIV clinic was suggested.

25. The man attended a Crown Court in London for trial from 4 to 11 April. During that period, on 5 April, a nurse was called to him at court when he became unwell with his asthma. He was treated and deemed fit to recommence the trial and to be transported in a cellular vehicle. On 6 April, an untimed entry on the Continuous Clinical Record shows that the man was "now on A wing" and notes briefly his medical history and that he needed re-weighing, a dental and an optician's appointment. He was also given a repeat prescription of Ranitidine. On 11 April, the man was convicted and remanded in custody pending sentence. On his return to prison he received Zopiclone for his insomnia and on 21 May he was prescribed Vitamin B. The man saw the dentist on 3 May for an examination and was subsequently treated on 17 May.

26. On 8 May, the man again complained of multiple lumps on his body and burning sensation on his hands. He asked to see the HIV specialist whom he had last seen some months previously. An appointment was made for him to see a doctor at the NMH on 24 May. He attended under escort and his case was reviewed by the clinical team. He was prescribed Gabapentin 300mg for his peripheral neuropathy (pain in the nerve endings) and Lyclear cream for a skin rash. He also received a follow up appointment for 6 June to see his supervising doctor and a neurologist. On

27. The Crown Court requested a medical report on 31 May because the man's medical condition and life expectancy were relevant to the length of sentence the court would impose. The report was written on 2 June by a doctor. A copy of that report is not filed in the man's record.

28. The man who died requested Salbutamol nebulisers on 9 June. His chest was clear and no respiratory distress was noted. He was advised to stop smoking and was shown the technique for use of his inhalers. On 22 June, the man was sentenced at a Crown Court to life imprisonment with a minimum term to serve set at six years. He was taken to HMP Wandsworth.

29. On reception at Wandsworth the man was noted in his Continuous Clinical Record to be taking Gabapentin for spinal pain and Ensure. His Prescription Chart also records that he was in possession of medication for his asthma, stomach ulcer and his skin condition. He was referred to the GUM clinic. The following day, 23 June, he saw a doctor who prescribed Gabapentin three times daily. The man remained on Gabapentin until August 2007. By 29 June he was noted in his Continuous Medical Record as demanding unprescribed medication from nursing staff and being non compliant with taking his regular medication. The record goes on to indicate that an urgent GUM appointment was made which he attended the same day. The Prescription and Administration Record Chart shows that two inhalers and Ranitidine were prescribed and issued to the man at the clinic. However he became argumentative the following day when he demanded nebulisers and refused to be examined. This situation continued with increasing friction until 15 July when the man was interviewed by a doctor. The doctor at Wandsworth contacted the lead doctor at Pentonville about his treatment. The Wandsworth doctor had contacted the man's doctor on 1 December 2005 but that doctor did not confirm that the man who died had been on nebulisers. The entry concludes with a note that the man should be re-assessed and might need a change of treatment. No alteration in his medication is evident at this stage.

30. On 4 August, the man who died received an antibiotic for an infected toe. During the evening of 23 September he reported experiencing chest pain and was seen by the duty doctor and the evening duty nurse who took his physical observations. Night staff noted that no further complaints were made.

31. The man reported on 2 October that he was experiencing pain all over his body. He was referred to the GUM clinic and further referred on 19 October to the supervising doctor at the NMH. The supervising doctor informed the medical staff at Wandsworth that the man was not currently prescribed any HIV medication.

32. A letter was received at Wandsworth on 23 November from the NMH stating that the man's medication was being changed and that the proposed anti HIV therapy was initially for a period of three to six months. It comprised one Combivir tablet twice daily and two tablets of Kaletra (Meltrex) twice daily. The letter detailed the possible side effects, mainly nausea, vomiting and diarrhoea, which hospital staff had warned the man about and explained the treatment for them. The hospital also asked that

33. On 30 January 2007, the man's appeal against sentence was allowed substituting a minimum term of five years imprisonment before release could be considered. (The original term was six years.)

34. The man who died was experiencing difficulty in breathing on 14 February for which he was given amoxicillin, an antibiotic, for three weeks. He was also noted as smoking four cigarettes per day. On 19 February he reported sick, saying that he had a trapped nerve in his left shoulder. He was advised to exercise and to take painkillers as necessary. The following day, the man again reported sick, stating that he felt ill and that he was getting pain from his multiple lipomatosis.

35. An entry on the man's Continuous Medical Record (the exact date is unclear) in March 2007 reports that he approached a Registered General Nurse on the landing stating that his lipomas were uncomfortable and that he was in pain. The nurse wrote that he appeared pale and unwell and needed reviewing. The prison medical officer made an appointment for the man to see his supervising doctor at NMH on 26 April. No documentation is available to indicate whether he attended this appointment.

36. On 30 May and again on 4 June, the man complained of problems with his teeth. He was reassured by the doctor who saw him that no swelling was present and he was advised to see the dentist. He was given a dental appointment for 18 June. On 1 June, an internal memorandum from a member of the Roman Catholic Chaplaincy asked the medical staff to look into a complaint the man had made regarding treatment for a very ulcerated mouth.

37. On 6 June, a letter was received by the Governor at Wandsworth from the Irish Commission for Prisoners Overseas requesting that the man's proposed move to Swaleside be expedited. The letter referred to the difficulty that the man was having in accessing appropriate medication for a serious infection in his mouth. The man, on 26 June, was taken to the Accident and Emergency Department at St George's Hospital in London where he underwent an X-ray which showed an ulcerated swelling under one of his teeth. A diagnosis of a tooth abscess was made and biopsy samples were taken.

38. The man was transferred to HMP Swaleside on 28 June and was seen by medical staff at 4:45pm when he was given all his prescribed medication: Combivir, Kaletra DF118 (30mg), Ranitidine (150mg) and Gabapentin (600mg). He was also referred to see the prison doctor the following day for a review of his medication.

39. The man was reviewed on 10 July by a Consultant in GUM at Medway Maritime Hospital in respect of his HIV status and management. The consultant wrote that day to a Consultant Oncologist at Medway Hospital that the man's main complaints were weight loss and swelling on the left side of his neck and pain on swallowing.

40. The man returned from hospital to Swaleside but refused to be moved from his cell on E wing to the Healthcare Centre (HCC). Although he was in pain he preferred to remain in his normal location. A healthcare Care Plan was initiated on 13 July and the man agreed to be admitted to HCC to facilitate the Care Plan. An urgent referral was made to a doctor at a local hospice. Advice was also sought from a Speech and Language Therapist at the local community hospital regarding the difficulties the man experienced when swallowing. Her advice led to an adjustment of his diet to ease those difficulties.

41. A Registered General Nurse who was the Palliative Care Link Nurse (PCLN) at Swaleside wrote on 17 July to the hospice doctor seeking advice on the care and management that the man would need. Her main concerns were about his pain management and support for his emotional and psychological needs. A reply from a hospice doctor was received at Swaleside on 23 July regarding the man's medication and an assessment of his needs. The Hospice Domiciliary Team was to become involved.

42. MRI and CT scans took place and showed that the man had a soft tissue mass on the left side of his palate, but there was no conclusive evidence to suggest that it had spread to other parts of his body. A note in the Continuous Clinical Record on 23 July says that he was experiencing breakthrough pain (pain felt by the patient during a regime of pain killing medication) for which the senior medical officer prescribed Ibuprofen. The man was unable to tolerate this medication and advice was sought by Swaleside from the hospice who recommended that his Oramorph be increased to 100mg at four hourly intervals and his Pregabalin to a twice daily dose of 75mg. A visit by the Hospice Domiciliary Team was arranged for 27 July and arrangements were made for the man to transfer extra private cash to his telephone account to enable better contact with his family.

43. On 26 July, the man spoke at length to the PCLN about his diagnosis and prognosis and his wishes that his family should be informed of his care and treatment. They discussed medical confidentiality and he agreed that he would sign a disclosure form in regard to his family, which he did on 27 July. He also gave his consent for the PCLN to be privy to any information with regard to him. The Swaleside Healthcare Senior Officer (HCSO) arranged a compassionate visit for his family.

44. A Macmillan Nurse from the hospice visited the man on 27 July and, on her advice, the Oramorph dosage was increased to 130mg at four hourly intervals and a dietary supplement (Fortisips) was given four times daily. The Macmillan Nurse discussed the man's illness, treatment and pain with him at length. They also discussed the radio and chemotherapies that he was due to start. The Macmillan Nurse agreed to see him again on 1 August when she hoped to have more information about his prognosis which was his main concern. He felt that the issue was being skirted around.

45. The man had a visit from his family on 29 July during which the PCLN spoke to his partner about his care. The following day, the man became ill after taking his Oramorph and was given Metoclopomide to combat this side effect.

46. On 1 August, the man and the Macmillan Nurse met for the second time. They discussed his future treatment after which he felt that he could look forward and that he was more in control. The PCLN also spoke to the man's partner to make her aware of the present situation and to give her contact details for the Macmillan Nurse.

47. An undated entry on the man's Continuous Clinical Record says that a verbal and faxed instruction was received regarding the action to take should his carotid artery be compromised by the cancer in his neck. Such a compromise could lead to a very serious blood loss from which the man might not recover. The note identified the response required and concluded that his treatment was to be reviewed by the hospice staff.

48. The man was admitted to Hospital X on 2 August to begin his chemotherapy. He was discharged the following day with a letter from the oncology dietician who wrote that he required nutritional support to increase his weight and tolerance to his treatment. The man then had a period of experiencing diminished appetite and dietary adjustments were made to assist him. Adjustments were also made to his drug regime.

49. The Continuous Clinical Record holds a note written by the prison doctor on 3 September about a letter from a doctor at the Oncology Centre. The Oncology doctor suggested that the man's tumour had reduced in size and he could expect to feel less pain so his medication should be reduced. The man disagreed with the notion that he was in less pain and so the medication was maintained at the previous dosage pending a review by hospice staff within the next few days.

50. On 5 September, the Macmillan Nurse and other staff from the hospice saw the man. They jointly agreed that he was now considered to be terminally ill and believed him to have only a matter of weeks of life left. A note written on the man's Continuous Clinical Record on the same day by the prison doctor says that consideration should be given to early release on compassionate grounds and the process of securing release was started. A letter from the Oncology Centre indicated that a follow up appointment for the oncologist's clinic had been made for 13 September.

51. The PCLN discussed the man's physical and mental well being with him at length on 9 September. She recorded her belief that he was still in denial as to how poorly he

52. On 12 September, the PCLN noted that the man was very low. The Macmillan Nurse had offered a bed at the hospice but was unable to discuss the matter until the following day. The man was prescribed Amoxicillin 500mg for a chest infection, to be taken three times daily. The following day the man declined to attend the oncologist's clinic at Hospital X.

53. Also on 13 September, a doctor and the Macmillan Nurse from the hospice reviewed the man's case with him at Swaleside. The PCLN was also present. The doctor suggested that hospice admission might be appropriate. She explained to the man that the current treatment he was receiving was with the aim of curing his cancer but he ran the risk of an infection. The doctor advised that, should his condition deteriorate, admission to hospital for active management would be appropriate. A Care Plan to that effect was written and signed by the prison Senior Medical Officer.

54. A letter from the oncologist at Hospital X dated 19 September was received at Swaleside requesting that the man attend the Oncology Centre to have a percutaneous endoscopic gastrostomy (PEG) feeding tube inserted because he was experiencing pain and difficulty swallowing, (PEG tubes are inserted directly through the stomach wall.) The doctor wished to improve the man's nutritional status whilst he underwent his third cycle of chemotherapy before receiving radiotherapy. A note on the Continuous Clinical Record dated 21 September says that Swaleside made contact with Hospital X to arrange admission for the insertion of the PEG feeder. The man was confused and disorientated and was having difficulty remembering to take his medication. His in possession medication was therefore returned to HCC staff and was issued by them at the appropriate times.

55. On 25 September, the man refused to leave Swaleside to attend his hospital appointment because he was apprehensive about the PEG insertion. The Healthcare Manager discussed the matter with him, cancelled the appointment and rebooked it for 5 October at a Day Care Centre.

56. The man was reviewed on 1 October and, because of his condition, a decision to admit him to outside hospital was made. The oncologist was contacted and briefed and requested that the man be admitted to Hospital X. He also asked for a saline drip to be administered, but on that day no suitably trained staff were on duty. The man was discharged from Swaleside for admission to Hospital X at 1:24pm. On 2 October, the Senior Medical Officer at Swaleside completed the medical recommendation for release on compassionate grounds and gave it to the duty governor. The PCLN contacted the ward at Hospital X where the man was reported to be comfortable and noted that the PEG tube was to be fitted one week later. The Macmillan Nurse at the hospice was informed of these developments.

57. The man was unexpectedly discharged from Hospital X on 4 October and returned to Swaleside during the afternoon. He was due to attend a Day Care Centre at

58. On the morning of 5 October, the man refused to attend the Day Care Centre, citing his recent discharge from Hospital X and the effects of the treatment he had received. The appointment was cancelled and another appointment was requested. During the afternoon the PCLN and the Macmillan Nurse reviewed the man's medication.

59. On 6 and 7 October, the PCLN spoke to both the man and his partner about his feelings and how he was coping. The man agreed to allow some limited information to be given to his partner's sister so that she could support her sister more effectively. The man was at a low ebb but opted not to take anti depressant drugs. He also agreed to have the PEG feeder inserted, realising that it would give him a measure of control over his medication and nutritional intake. The ward at Hospital X was contacted, admission was booked for 9 October and the operation date was set for 10 October.

60. The operation went ahead as arranged and the man returned to Swaleside in the early evening of 12 October. His medication was administered via the PEG using syringes until an automatic PEG feeder system was delivered. The man's Care Plan Evaluation notes show that on 14 October he was much more settled and his nutrition, fluids and medication were taken without too much discomfort. It also notes that the man was determined to be as independent as was possible. An undated Care Plan was written and signed by the prison senior medical officer to support the use of the PEG system.

61. Following treatment at Hospital X, the man was returned to Swaleside at 0:45am on the morning of 17 October, having refused to remain overnight at the hospital. Because he felt weak and tired, he also declined to return to the hospital at 7:00am the same morning for further treatment.

62. The automatic PEG feeder system was delivered to Swaleside on 18 October. Staff from the PEG suppliers and the Macmillan Nurse, came to instruct Swaleside HCC staff in its use. At about 3:45pm the PCLN discovered that faecal matter was leaking at the man's PEG entry site. Because of the potentially serious consequences an emergency ambulance was called to take him to Medway Hospital. The man was admitted to the Medical Assessment Ward at Medway Hospital where the PEG feeder was removed. He was then fed and medicated via a naso-gastric tube, something he was not comfortable with. He was transferred to Hospital X to allow the continuation of his radio and chemo therapies. He was to remain there until 6 December.

63. A referral was heard by the Parole Board on 2 November recommending that the man be released from prison on compassionate grounds. The application was approved, specifying that the licence conditions included accommodation in an approved hospice dedicated to terminal care.

64. On 5 November, a note on the man's Continuous Clinical Record indicated that he refused medication, his condition was deteriorating and his prognosis was poor. Maidstone and Tunbridge Wells NHS Trust completed a "Not for Attempted Cardio-Pulmonary Resuscitation Status Form" on 6 November, signed by two doctors. It indicated that, because of the severity of the man's medical condition, he was not to be resuscitated (known as a DNR). No indication is given whether this matter was discussed with the man or his family. A note appended to the document, dated 21 December and signed by the hospice doctor, confirmed the DNR decision.

65. In early November, the man's partner contacted the Swaleside HCPO, requesting that the HCSO, with whom the man and his family had a good relationship, go to Hospital X. She and the man's sisters, who are both nurses, were concerned about the quality of care that he was receiving and he appeared to have given up. The family said that the man was better off in Swaleside rather than the hospital. The HCPO approved the visit to the hospital but reminded the HCSO that he had no authority there. On arrival at Hospital X the HCSO spoke at length to the man, who felt isolated and down in mood, and discussed his medication with the doctor. The tone of the entries made in the Continuous Clinical Record on 9 and 15 November indicates that the Swaleside clinical staff were also concerned at the quality of care the man was receiving. The HCSO and the PCLN made several further visits to the man at Hospital X and the PCLN maintained contact with his partner, the Macmillan Nurse, the Speech and Language therapist and the dietician in an attempt to make the man's situation more tolerable.

66. A Maidstone and Tunbridge Wells NHS Trust Wound Assessment Chart dated 29 November indicates that a new PEG feeding tube had been fitted in a different location from the original site. A separate Wound Assessment Chart dated the same day shows that the man was also suffering from a pressure ulcer on his sacrum (the lower spine just above the buttocks). A Maidstone and Tunbridge Wells NHS Transfer Summary, again dated 29 November, indicates that the man had completed his radiotherapy but was unfit for chemotherapy at the time. The Transfer Summary noted that he had a naso-gastric feeding tube in place and listed the medication he was taking. There was a further note that, in the event of a cardiac arrest, the man was not to be resuscitated. In the event the man was not transferred back to Swaleside and remained in hospital.

67. The man was eventually discharged from hospital and returned to Swaleside on 6 December. On his arrival at the HCC, nursing staff noted that he was suffering from pressure sores and MRSA at the PEG feeder site. The medication accompanying him from the hospital was to treat the MRSA. He had become frail and weak, had lost muscle tone and his mouth secretions had increased. Staff at Swaleside photographed the man's pressure sores with his permission. At 3:00pm the following day, 7 December, HCC staff could not rouse the man and were concerned about his breathing. He was returned to Hospital X by emergency ambulance. He remained in hospital until the early evening of 18 December when he returned to Swaleside.

68. On the man's return to the HCC nursing staff noted that he looked emaciated and jaundiced and was unable to walk. His nursing care became much more intensive and included a large element of personal nursing care which the HCSO estimated

69. The PCLN was concerned about the man's condition and spoke to the Macmillan Nurse who arranged for the hospice doctor to visit him at the prison on 21 December. At interview the PCLN said that it was at about this time that the man accepted the seriousness of his situation.

70. The National Offender Management Service notified Swaleside on 21 December that the man had been granted release on life licence on compassionate grounds and the provisional release date was set for 22 December.

71. Also on 21 December, the hospice doctor visited Swaleside and was of the opinion that the man was deteriorating. The doctor considered that the man's remaining lifespan was a matter of days and agreed to take him into the hospice the following day, Saturday 22 December. The doctor added a DNR note to the man's medical notes.

72. On 22 December, the HCSO authorised and organised the man's transfer to the hospice by private ambulance, as PCT ambulance services were not available for such transfers at the weekend. The man's property and money accompanied him. Although the man had been released from custody, both the HCSO and the PCLN maintained close contact with the hospice and the man's family until his death. The man died at 1:05am on 2 January 2008.

After the man's death

73. The hospice manager broke the news of the man's death to his family and later informed the HCC at Swaleside. As the man had been released from custody on compassionate grounds, the Swaleside contingency plan for a death in custody was not activated. However, the Swaleside family liaison officer acted in support of the man's family as did the Governor and Chaplain at Swaleside. The Chaplain had remained at the hospice following the death saying prayers for the man who died and his family.

74. On 15 January 2008, a memorial service was held at Swaleside which was attended by members of the man's family, prisoners and staff. After the service, staff who knew and had cared for the man who died met his family in the prison boardroom.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical Care

75. The man's health was seriously compromised by HIV and Hepatitis C which had already been diagnosed in 1999 before he arrived at Swaleside on 28 June 2007. His health was further compromised when a diagnosis of squamous cell carcinoma (a cancer of the skin and mouth) in his mouth and neck was made in July 2007.

76. Whilst at Wandsworth the man originally complained on 30 May 2007 of facial soreness and difficulty in swallowing. He was referred to the dentist and was seen on 18 June. The dental consultation triggered a referral to St George's Hospital where a biopsy was taken. On 28 June, the man was transferred to Swaleside where on 12 July he was given the diagnosis that he had cancer. He then embarked on a regime of radiotherapy and chemotherapy. The cancer was aggressive and progressed rapidly despite treatment. It is possible that his body's lowered resistance to the cancer, because of his HIV and Hepatitis C status, was in part responsible for the rapid spread of the cancer.

77. The clinical review was based on the man's prison medical record. It included an assessment of the care provided for him throughout his sentence focussing on that provided by staff at Swaleside after his reception there until his death on 2 January 2008.

78. The clinical reviewer said in his report that the short delay between the man's first complaint of facial pain and the diagnosis of cancer did not diminish the benefit he might have achieved from the treatment he eventually received.

79. The clinical reviewer also wrote of the man's care at Swaleside "The medical and nursing care he received following his diagnosis were exemplary and certainly comparable with anything he might have received had he been based in the community. This rare, complex, and distressing malignancy was managed by all concerned with compassion and professionalism."

80. I often comment on shortcomings related to the medical treatment of prisoners. In this case I commend the medical staff at Swaleside for the lengths to which they went for a protracted period of time to ensure that the man's needs were met. While many more staff were involved I would single out the PCLN for her compassion toward the man who died and his family and the professionalism she showed during a difficult, complex and often emotional time. I also commend the HCSO for his compassion toward the man and his family and his willingness to become involved with the case to a level that is unusual and deserves recognition.

Early release on compassionate grounds

81. Swaleside healthcare staff were aware of the seriousness of the man's illness and the likely outcome soon after his reception. On 5 September the senior medical

"10(1) The Secretary of State may at any time release a prisoner if he is satisfied that exceptional circumstances exist which justify the prisoner's release on compassionate grounds."

82. On 21 December 2007, the man's application was granted and a provisional date of 22 December was set for his release. He was released on that day to be admitted to the hospice. It is evident that Swaleside took early account of all the circumstances surrounding the man's situation. They took appropriate steps in initiating the procedure for early release on compassionate grounds and when the time came the man's release and transfer to the hospice was, particularly as it happened during the Christmas period, dignified and without delay.

Family issues

83. The man's partner spoke over the telephone to my Family Liaison Officer (FLO) during January 2008. She felt that Swaleside had been very good with him and that he had been well cared for whilst there. Her only concern was that he had sometimes felt frustrated at not receiving more notice of outside hospital visits. He had found it hard not having more time to prepare before his treatment. The FLO explained the security issues surrounding the escorting of prisoners to outside hospital. The man's partner subsequently wrote a letter on 11 February to the FLO clarifying that the reason that the man had become frustrated was because he did not like going out to the hospital irrespective of whether he had prior warning or not. She felt that staff were always empathetic and supportive of him and staff prepared him properly in advance of any treatment he was due to receive. The man's sister also wrote a letter on 1 March commending the treatment of her brother by Swaleside staff.

84. The man's partner described healthcare staff at Swaleside as being 'brilliant'. However, she and the man's sister, a nurse, had significant concerns about the care and treatment he received whilst at outside hospital. She mentioned that the man had preferred prison healthcare to that given at the outside hospital because he felt he received better care at Swaleside. The FLO explained that, although a separate clinical review would be commissioned to consider the appropriateness of the healthcare the man received whilst in prison, the investigation would not be able to consider the healthcare he received whilst in outside hospital. The FLO suggested that consideration be given by the family to contacting the Parliamentary and Health Service Ombudsman for whom she provided contact details.

CONCLUSION

85. The man's serious health problems were known by the court when he was imprisoned on 30 November 2005. On his arrival at HMP Pentonville, his medical conditions were noted and confirmation of his medication was obtained promptly from his doctor at the North Middlesex University Hospital.

86. Following sentence on 19 December 2005, the man was taken to HMP Wormwood Scrubs and in February 2006, after a further court appearance, was returned to Pentonville. In June 2006, after further sentencing at Middlesex Guildhall, he went to HMP Wandsworth.

87. Throughout the early part of his sentence until he was transferred to HMP Swaleside the man was receiving appropriate medication for his medical conditions. During that time he was also making regular visits from prison to specialist clinics to monitor his health. Because of the frequent movement between prisons it was sometimes difficult to maintain the medicinal and dietary regime to which the man had become accustomed. Additionally the man had a good knowledge of his conditions and the medication he had been prescribed. He was frustrated by what he saw as a lack of continuity and this, unsurprisingly, led to some confrontation between him and healthcare staff. In the main they dealt with these issues promptly and in a sympathetic manner.

88. The man who died saw the Medical Officer at Wandsworth complaining of facial soreness and problems with swallowing. He was referred to the dentist and as a result he was further referred for a biopsy just prior to his transfer to Swaleside. The man's medical status and management regime were reviewed 12 days later by a GUM consultant at Medway Maritime Hospital, Rochester. After receiving the biopsy results, the consultant immediately referred the man to the consultant oncologist. The biopsy result showed that he had a squamous cell carcinoma. He was seen by the oncologist who informed him of the diagnosis and the need to start treatment urgently. Standard and recommended regimes of radiotherapy and chemotherapy were then undertaken.

89. There was a delay between the man's first complaint of facial pain and the establishment of his diagnosis by means of a biopsy but this delay did not, in the opinion of the clinical reviewer compromise any result he might have achieved from the treatment he received.

90. A care plan was initiated for the man on admission to Swaleside HCC. The clinical reviewer examined the entries in the care plan and found that the standard of care and supervision exhibited was exemplary, a view I have no hesitation in endorsing.

91. An urgent referral was made to the doctor at the local hospice and advice was also sought from a Speech and Language Therapist about the difficulties the man was experiencing. Her advice led to a prompt adjustment of his diet to ease those difficulties. After hospice staff saw the man, he was regarded as having a terminal illness and the prison senior medical officer properly started the process for early release on compassionate grounds.

92. As the man's cancer progressed he found greater difficulty swallowing both food and medication. An operation to insert a percutaneous endoscopic gastrostomy (PEG) feeding tube directly into his stomach was offered. The operation was scheduled and cancelled several times because of the man's understandable apprehension about the procedure. The healthcare manager discussed it with him and the operation was rebooked. However before the operation could take place the man's physical condition deteriorated and he was admitted to Hospital X. Following his return to Swaleside he again refused to attend the hospital for the operation to insert the tube. He finally agreed to have it inserted and after a successful operation the man was much more comfortable, taking nourishment and medication and was returned to Swaleside on 12 October.

93. Following further treatment at Hospital X, the man was returned to Swaleside on 17 October. The following day the PCLN at Swaleside discovered a leakage at the man's PEG tube entry site. In view of the serious consequences of the leakage he was immediately sent to Medway Hospital by emergency ambulance where hospital staff removed the PEG feeder. The man was then transferred to Hospital X for continuation of his radiotherapy and chemotherapy and the insertion of a new PEG feeder tube. He remained in hospital until 6 December when he was returned to Swaleside. The following day HCC staff were unable to rouse him and he was re-admitted to Hospital X by emergency ambulance. He remained there until 18 December when he was returned to Swaleside. From that point, the man's nursing care became much more intensive and he remained unlocked at all times to facilitate quick and unfettered access to him by medical staff.

94. The hospice doctor saw the man at Swaleside on 21 December and offered him a place at the hospice. On the same day the man was granted release on life licence on compassionate grounds. He was admitted to the hospice the following day.

95. Although the man had been released from custody both the HCSO and the PCLN, his main professional support from the time of his reception at Swaleside until his death, maintained close contact with the hospice and the man's family until his death on 2 January 2008.

96. Although many other people worked closely with the man who died to ensure that he had all that he needed it was these two prison staff, the PCLN and the HCSO, who had prolonged contact with him and his family during what was for all concerned a harrowing time. They made extraordinary efforts to ensure that he was able to have the correct diet and treatment and, more importantly, was able to hold on to as much dignity as was possible in the last months of his life. I recommend that the Governor considers how the compassion and dedication of the PCLN and the HCSO should be most appropriately recognised.

97. The man who died was a determined man who wanted to be independent and, as far as was possible, to be in control of his medication. It is a testament to that fact and the sympathetic way Swaleside and hospice staff interacted with him and his family that the man had a measure of dignity during what the clinical reviewer described as a miserable and distressing time leading up to his death. The clinical reviewer also wrote that "medical and nursing care he received following his diagnosis was exemplary and certainly comparable with anything he might have received had he

98. I find that the staff at Swaleside acted in a timely manner at all the key stages throughout the man's illness, ensuring that his needs were met and indeed often exceeded. This allowed the man and his family to focus on each other without the need to take time and energy to surmount unnecessary obstacles. The Governor and staff at Swaleside should take considerable satisfaction from that fact.

Recommendation

I recommend that the Governor considers how the compassion and dedication of the PCLN and the HCSO should be most appropriately recognised.

A response to the draft report was received from the Prison Service on 8 October 2008 noting that "It is encouraging to receive such a positive report on Swaleside and Healthcare in particular."

I am pleased that the recommendation I made to the Governor was positively received and will be taken forward in the most appropriate manner.