Investigation into the circumstances surrounding the death of a man at HMP Garth in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

November 2009

This is the report of an investigation into the death of a man. He was 65 years old when he died from natural causes at HMP Garth in January 2009.

The man was first suspected of having lung cancer in November 2007. Following a series of tests he underwent an operation in the spring and a diagnosis of cancer in his right lung was confirmed. Chemotherapy was planned but not begun due to an oversight by the hospital. In September 2008, it was found that the cancer had spread to the man's brain. He elected to withdraw from any further treatment and to die in the healthcare centre at Garth. The man's health deteriorated over the next few months and his death in January 2009 was expected.

I would like to extend my condolences to the man's relatives and all those who have been affected by his death. I understand that members of the healthcare team at Garth developed a strong rapport with him.

The investigation was completed by my colleague. He has visited Garth and spoken with healthcare staff. One of the Family Liaison team contacted the man's brother and informed him about my investigation. He did not express any concerns with regard to the treatment the man received. In fact, he wrote to the healthcare team thanking them for the care they gave his brother.

A clinical review of the treatment which the man received in custody was undertaken by the clinical reviewer appointed by the local Primary Care Trust (PCT). He has assessed whether the care that the man received in custody was comparable to that he would have been offered in the community. I am grateful to the clinical reviewer for his assistance. A copy of his review is annexed to my report.

I would like to express my thanks to the Governor and the staff and prisoners at Garth for their full cooperation whilst the investigation took place. I especially thank the prison's liaison officer who helped the investigator.

I consider that the care which the man received was largely exemplary. The specialist nurse who visited him from the local hospice told the investigator that she was impressed by the way the healthcare team handled his deteriorating condition.

However, the man's initial treatment fell outside of NHS guidelines. Additionally, he did not undergo chemotherapy following his operation in spring 2008, as had been planned. By the time the latter delay was highlighted by the man himself, the window of opportunity for this treatment had passed. A review conducted by the NHS concluded that a breakdown in communication at the hospital resulted in the failure to offer this treatment. Nonetheless, I consider that the healthcare team at Garth might have made more efforts to proactively check on the progress of the proposed treatment.

I make five recommendations and endorse two made by the clinical reviewer.

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

Jane Webb
Deputy Prisons and Probation Ombudsman **November 2009**

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SUMMARY

The man appeared at Crawley Magistrates' Court in December 1999 in relation to an offence of murder. He arrived at HMP High Down the same day and subsequently transferred to HMP Lewes in March 2000. At the end of that year the man received a life sentence at Lewes Crown Court. He was transferred to HMP Wormwood Scrubs and then, in November 2004, to HMP Garth.

Three years later, in November 2007, the man complained of symptoms which led the healthcare staff to suspect that he might have lung cancer. He underwent a series of tests over the New Year period, and it was decided that he would have an operation to remove the tumour in his lung. Surgery took place at Blackpool Victoria Hospital on 31 March 2008.

After the man returned to the prison, it was decided in early May that he would undergo a course of chemotherapy. However, a potentially malignant growth on his thyroid gland had to be examined by a consultant before this treatment could begin. Although the consultant who carried out this examination agreed to the course of chemotherapy, no appointments were made. It subsequently emerged that miscommunication between the different hospital departments had led to the treatment being placed 'on hold'.

On 6 August, the man complained to healthcare staff at the prison that he had not begun the course of chemotherapy. He was sent immediately to hospital, where he was told that the window of opportunity following surgery had passed and chemotherapy could not now take place. A scan at the start of September appeared to indicate that the cancer had not returned.

However, on 18 September the man was readmitted to hospital. A few days later he was told that the cancer had spread to his brain. The man then chose to return to the prison on 27 September and refuse all further treatment. He stayed in the healthcare centre as his health declined over the next few months. His care was overseen by a specialist nurse from the local hospice. The man was visited by his relatives before he died on 13 January 2009 in his cell, in the presence of two nurses.

My investigation has highlighted a delay in commencing the man's treatment and then a further delay in providing the chemotherapy treatment he was promised. Whilst an investigation carried out by the NHS found that a failure in communication within the hospital led to the latter oversight, I have discussed the need for the healthcare team at the prison to be more proactive in pursuing prisoners' treatment.

Although the clinical review has highlighted other concerns relating to an error in giving medication and poor record keeping, I have been largely impressed with the level of care offered to the man in the last few months of his life. The Governor and healthcare staff are to be praised for the dedication they showed in helping him to die according to his wishes. This was noteworthy because it was the first time that a terminally ill man had chosen to die at the prison.

THE INVESTIGATION PROCESS

1. The investigator was formally notified of the man's death on 14 January 2009. Notices were issued to both staff and prisoners at HMP Garth, informing them of the investigation process and giving them the opportunity to contact my colleague if they felt that they could provide relevant information. No prisoner came forward, but the investigator spoke informally with one of those living in the healthcare centre when he visited the prison.

2. The investigator contacted the prison's liaison officer. He provided the investigator with all records relating to the man's time in custody.

3. Having examined the relevant documents relating to the man's time in Garth and the medical treatment he received, the investigator visited the prison on 3 March 2009. He interviewed the Head of Healthcare.

4. My colleague wrote to the local Coroner's office to inform them of the nature and scope of the investigation report. HM Coroner will be provided with a copy of my report.

5. The investigator also contacted the local Primary Care Trust (PCT) and asked that a clinical review be carried out with regard to the medical treatment that the man received in custody. The purpose of the review is to establish whether the care which he received in prison was comparable with that he would have been offered in the community. The clinical review is annexed to my report.

6. On 10 February 2009, one of the Family Liaison team telephoned the man's brother, who was his listed next of kin. The Family Liaison Officer provided information about the investigation and subsequently wrote to the family. The family did not raise any concerns about the care the man received.

HMP GARTH

7. HMP Garth is a category B training prison holding men who have committed serious offences and who are serving either long or life sentences. Garth opened in 1988 and, following expansions in 1997 and 2007, has an operational capacity of 847 prisoners. The prison is located near the town of Leyland in Lancashire.

8. Since April 2004, the Ombudsman has investigated four previous deaths at Garth, all of which were attributable to natural causes. The investigation into the death of a prisoner in December 2007 (published in October 2008) invites comparison with the man's experiences. The Ombudsman recommended that the healthcare team should improve the provision of care for those prisoners who are terminally ill. The prison accepted that further improvements needed to be made in this regard. I am very pleased to report that the nurse from the local hospice was impressed with the care the man was given.

9. However, the earlier investigation also led the Ombudsman to recommend that the healthcare team needed to clarify whether they or the hospital should take responsibility for the progression of a prisoner's treatment. There were delays referring the prisoner to the appropriate specialist because it was not clear who would coordinate his care and follow up the outpatient appointments.

10. A similar problem arose during the man's treatment, when his chemotherapy was essentially overlooked between May and August 2008. Neither the hospital nor the prison pursued the proposed course of action and the man himself had to highlight the problem. The same issue was touched upon during the investigation of the death of another prisoner in September 2006 (published in July 2007). The Ombudsman recommended that healthcare staff should note the contents of hospital correspondence to ensure that any follow-up outpatient appointments were attended.

11. The commissioning of healthcare at Garth is the responsibility of the local Primary Care Trust (PCT). The prison has 24 hour nursing cover seven days a week and an inpatient facility comprising of eight beds. The majority of healthcare staff work between 8.00am and 5.00pm during the week. Staffing is reduced from 5.00pm into the evening, and again during the night.

12. The usual healthcare staffing levels were increased whilst the man was an inpatient. There is normally one nurse in the healthcare centre overnight, but whilst he was living there in his last few months, an additional nurse worked the night shift. At weekends, four staff usually work during the daytime. Whilst the man was a patient, this staffing level was increased to five to ensure that he was properly cared for.

13. Doctors hold surgeries at Garth on weekday mornings. A full time nurse practitioner (who has more advanced skills and training than a nurse) is on site during the week. At other times the local out of hours telephone service is

consulted if nursing staff either require a doctor’s advice or consider that emergency treatment may be needed.

14. An unannounced inspection of Garth was conducted by HM Chief Inspector of Prisons between 5 and 7 March 2007. HM Chief Inspector found that Garth remained ‘an essentially safe, respectful and active prison’. She commended staff on the progress they had made, and stated her belief that the delivery of healthcare to prisoners continued to improve.

15. The most recent annual report published by the Independent Monitoring Board (IMB) at Garth covers the year from 1 April 2007 to 31 March 2008. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB commented that Garth was ‘extremely well managed’. They felt that prisoners were treated ‘… fairly [and] with complete respect…’

KEY FINDINGS

16. The man arrived at HMP Highdown in December 1999, after appearing at Crawley Magistrates' Court in Sussex in relation to an offence of murder committed in July of that year. His case was committed to Lewes Crown Court. A first reception health screening was completed and no significant health problems were identified.

17. In the year that followed, the man remained on remand in prison. He was transferred to HMP Lewes in March 2000. Later that month, the man underwent psychiatric assessment, but was not found to have a mental illness. He made numerous appearances at court before his trial started, and was usually assessed by a member of healthcare staff before he left the prison on each occasion. He never reported any problems and would sometimes refuse to see the healthcare team at all.

18. A year after he was arrested, the man was convicted of murder at Lewes Crown Court. In December 2000, he received a life sentence. He subsequently transferred to HMP Wormwood Scrubs in London.

19. Over the next few years, the man's health was generally stable, aside from headaches which he said he had suffered from since the 1970s. He reported some shortness of breath at a well man clinic in March 2002. He was advised either to stop smoking or reduce the amount he smoked. In May 2004, a lipoma (a non-cancerous fatty lump) was removed from his shoulder blade. Later that year, in November 2004, the man transferred to HMP Garth. A further reception health screening was completed, but no health concerns were noted.

20. The first signs of the man's illness appeared three years later in November 2007. On 21 November, he was assessed by a doctor. Recent sudden weight loss was recorded and the man reported muscular pain across his body. It was noted that he had been a heavy smoker for close to 40 years. In order to explore his symptoms, routine blood tests were ordered by a doctor and the man was referred to the respiratory clinic run by the nurses at Garth.

21. A few days later, on 26 November, the man was assessed by a nurse in the respiratory clinic. A spirometry test (to check how well his lungs were working) was carried out. On the basis of this test, it was clear that he needed further assessment. The nurse considered that an urgent chest x-ray was required, and arranged for the man to be examined by a doctor the following day. The doctor in turn referred the man to the hospital for an x-ray as well as prescribing medication to help with the shortness of breath he was experiencing.

22. The man was escorted to Chorley District Hospital in December and an x-ray was taken of his chest. The healthcare team at Garth were contacted by telephone by hospital staff on 12 December and told that the x-ray had revealed a five centimetre tumour at the top of the man's right lung. As a consequence, he was to be referred within two weeks to a respiratory

specialist. The man was told the same day that the results of the x-ray meant there was a high probability that he had lung cancer. He was offered the chance to stay in the healthcare centre, but did not take up the option at this stage.

23. On 20 December, the man was escorted to the Royal Preston Hospital, where he was examined by a specialist in the respiratory medicine clinic (which deals with illnesses relating to the chest). He was referred for further tests and, on 2 January, underwent a computerised tomography (CT) scan (which allows medical staff to look at images of the inside of a patient's body).

24. Two days later a bronchoscopy was carried out (this is a procedure involving the insertion of a tube through the mouth and down the throat to visualise the tumour in the lung). The results of the bronchoscopy were inconclusive and on 8 January, the man visited the hospital to undergo a positron emission tomography (PET) scan (producing a three dimensional image of the inside of the body).

25. The next day, the man complained to prison staff that he was missing out on meals because of his hospital visits. It was confirmed that he had to fast before tests were carried out, but that a meal would be provided on his return from hospital.

26. The man was reviewed by hospital staff on 14 January and the respiratory clinic referred him to the oncology department (which treats patients with cancer). Three days later, on 17 January, he underwent a lung biopsy (a small operation which removes potentially malignant tissue for further diagnosis). This procedure was carried out with the guidance of CT imaging (which produces pictures of the inside of the body that help to guide the doctor to the affected area). A fine needle aspiration biopsy (a procedure involving the insertion of a needle to remove possibly cancerous cells) was also performed on the man's thyroid gland (which staff were also concerned about).

27. The results of the test on the thyroid gland were received by the healthcare team on 28 January. A follicular lesion (a type of malignant growth) had been found. However, the lung tumour was still considered to be the more significant problem. The man was referred to a cardiothoracic surgeon (specialising in treating diseases in the heart, lungs and windpipe), who would perform a lobectomy (an operation to remove the affected part of the lung).

28. The man spoke with a prison doctor on 4 February and discussed his proposed treatment. He asked to move into the healthcare centre whilst he prepared for the operation and was relocated to a cell in the healthcare wing on 8 February.

29. A few days later, on 13 February, the man was due to go to an appointment at the Blackpool Victoria Hospital but did not attend. It appears that this was a result of the prison not escorting him rather than the hospital cancelling the appointment. The hospital recorded that the man had failed to attend. At the

beginning of March, he complained of chest pain on the left side of his body, which was spreading down his left arm. This pain continued over the next few days.

30. On 12 March, the man was escorted to Blackpool Victoria Hospital to be examined by the cardiothoracic surgeon and he was subsequently listed for surgery. (This was the assessment originally scheduled for 13 February.)

31. The man was admitted to the Blackpool Victoria Hospital between 30 March and 9 April. He was hand cuffed but the restraints were removed during surgery and for a while afterwards. On 31 March, he underwent a further bronchoscopy and a right thoracotomy (an incision into the chest to gain access to the lungs) before the cancerous growth and some surrounding tissue was removed. It was confirmed that the man had lung cancer (specifically adenocarcinoma of the right lung). After recovering from the operation, he returned to the healthcare centre at Garth on the evening of 9 April.

32. As a result of the operation, the man had been fitted with a chest drain (a tube which is inserted through the side of the chest to help the patient recover from surgery). After encountering difficulties with the drain, staff sent the man back to hospital on 29 April for an x-ray to make sure that the tube was properly positioned and functioning correctly.

33. The intention was for the man to receive adjuvant chemotherapy following surgery. (This type of chemotherapy is given when the surgeon believes that they have removed all detectable traces of a tumour but wants to reduce the likelihood of a recurrence.) The man went to an appointment with a doctor at the Rosemere Cancer Centre on 2 May to discuss the treatment. The doctor made an urgent referral to a consultant general surgeon on 6 May. Before chemotherapy could begin, a potential complication involving the man’s thyroid gland had to be assessed by a consultant general surgeon. A letter from the doctor at the Rosemere Cancer Centre to the healthcare team at Garth confirmed that the man was anxious to start chemotherapy treatment in the next few weeks.

34. A consultant general surgeon examined the man on 16 May, had a discussion with the consultant oncologist (who specialises in the treatment of cancer) and then gave the oncology department permission to begin chemotherapy. With the man’s agreement, the consultant general surgeon planned to manage the malignant growth on the thyroid gland (which was not directly related to the lung cancer) once the course of chemotherapy was completed. Given that the thyroid cancer was slow growing, it was felt that the lung cancer needed to be treated as the priority.

35. The consultant oncologist wrote to the healthcare team at Garth on 16 May informing them that, following the consultant general surgeon’s examination, a decision had been made to go ahead with chemotherapy at the Rosemere Cancer Centre in Preston. Three days later, on 19 May, the man’s recovery from surgery was reviewed by the respiratory clinic at the hospital. He stayed

overnight and returned to Garth the next day. A registrar wrote to the healthcare team at the prison, indicating that they would review his condition again following his course of chemotherapy.

36. On 29 May, the man left the healthcare centre, returning to live and work on the wing with other prisoners. Despite the intention to begin chemotherapy, he was not offered any appointments by the hospital. The healthcare staff at the prison did not receive any further correspondence from the hospital and did not contact the specialist to check on the progress of the proposed treatment. The man was examined by one of the prison doctors on 14 July. The doctor noted that he was waiting for an appointment, but no action was taken.

37. The man repeated his concerns to administrative staff in the healthcare centre on 6 August, asking why he had not yet been sent to the hospital for his chemotherapy treatment. It was the man's enquiry that led healthcare staff to call the consultant oncologist's secretary at the Rosemere Cancer Centre on 6 and 7 August. The error was quickly recognised and an appointment was scheduled for 8 August. (I have addressed the almost three month delay in treatment in the 'Issues' section of this report.)

38. On 8 August, the man was assessed by a locum oncologist. He was told that, because more than three months had passed since surgery, the time during which chemotherapy could be given had now passed, and so no further treatment would be offered until another CT scan had been performed.

39. A CT scan was carried out at hospital on 2 September to determine the current progress of the cancer. The man was told by a locum oncologist during a consultation three days later on 5 September that the scan had not shown any recurrence of the cancer and was 'clear'. It was agreed that chemotherapy would not now take place, and that the man's condition would be reviewed again within the next two to three months.

40. A week later, on 12 September, the man reported additional symptoms to the prison doctor. He complained of a feeling of numbness in the little finger of his left hand and a general loss of strength on his left side. By 16 September, the weakness in his left hand had worsened, and he was unable to perform simple tasks such as holding a knife and fork. The prison doctor consulted with the Rosemere Cancer Centre, who advised that the man's condition should be monitored for the next few days.

41. The man's condition did not improve and, following a discussion between the prison doctor and staff at Chorley District Hospital, he was admitted to their Medical Assessment Unit on 18 September. He was effectively wheelchair bound and, in view of his frail health, the decision was made by the Governor that restraints would not be used whilst he was in hospital (although the man would still be escorted by prison officers). On the first night of the man's stay the ward sister raised an objection to the absence of handcuffs, but the following morning it was agreed with prison staff that the restraints would not

be used. Escorting staff remained with the man throughout his stay in hospital.

42. On 22 September, the man underwent a further CT scan. Three days later, another oncologist confirmed that the man's lung cancer had spread to his brain. He was offered a course of radiotherapy in the next few weeks to try and manage his illness, and was told that he might expect to live for another six months if he had the treatment.

43. The man asked to return to Garth on 27 September to sort through his belongings prior to starting treatment. Once he was back in the prison in the mid-morning, he refused to leave again, stating that he did not want to undergo any further treatment. He signed a disclaimer the same day which confirmed his refusal of either radiotherapy or any other intervention. His withdrawal from all further follow-up treatment was acknowledged in letters by the second oncologist on 10 October and locum oncologist on 10 November. The man clearly expressed his desire to stay in Garth in familiar surroundings whilst his condition inevitably deteriorated.

44. From 27 September, the Governor gave permission for the man's cell door to be kept unlocked so that nursing staff could attend him at any time. He moved into a cell in the healthcare centre the same day which was equipped with a camera, to allow staff to monitor him easily. Two days later, on 29 September, a referral was made to the specialist palliative care team at St Catherine's Hospice. (They are experts in caring for terminally ill patients, reducing their pain and managing their symptoms as their health deteriorates.)

45. On the same day, consideration was given to transferring the man to nearby HMP Preston's regional prison hospital. Being much larger with 30 beds and better staffed, Preston was potentially better able to cope with the man's deteriorating health. However, he did not want to leave Garth. The Governor and the healthcare staff wanted to accommodate the man's wishes and agreed to look after him. A pressure relieving mattress was ordered to improve his comfort. This was the first time the staff at Garth had agreed to care for a patient with palliative care needs up to the point of death.

46. A specialist palliative care nurse from St Catherine's Hospice visited the man on 30 September to assist him with end of life care. He made it clear that he did not want any further treatment. The man was to be given pain relief and treated according to the guidelines set out in the Liverpool Care Pathway. (This is a recognised model of caring for terminally ill patients and the intention was that his treatment should be comparable to that which people receive in a hospice.) The specialist palliative care nurse and her colleagues would continue to visit the man very frequently until he died.

47. The man signed a document on 1 October confirming that he did not want to be resuscitated. On the same day, the plans agreed with the specialist palliative care nurse for the man's ongoing care were recorded in detail in his medical records.

48. The following day the man was admitted to Chorley District Hospital Accident and Emergency Department at 4.15am after suffering a seizure as a result of his brain tumour. He was escorted by one prison officer and was not handcuffed. After starting different medication to reduce the likelihood of further seizures, the man returned to Garth at 11.30pm that night.

49. Over the next three months, the man's condition gradually deteriorated. The healthcare team bought a new bed to cater for his needs and, as I have described, additional nursing cover was provided. For instance, the number of nurses working through the night increased from one to two. The man did not return to hospital and the healthcare team were guided by the specialist palliative care nurse's advice.

50. On 7 December, one of the nurses gave the man 16mg of dexamethasone in error (rather than his usual dose of 8mg). At 9.00am that day the healthcare team telephoned a local GP who regularly held surgeries at Garth. She advised them to monitor the man's condition, but did not express significant concerns about possible ill effects. The healthcare team also contacted the National Poisons Information Service (NPIS) in Cardiff to seek advice regarding the mistake. Staff at the NPIS told them to monitor the man's condition, but indicated that there was 'little risk of toxicity'.

51. Staff contacted the man's brother on 17 December and advised him that his brother's condition was deteriorating. The family took the opportunity to visit the man in the healthcare centre in the weeks before he died.

52. The man became very unwell over the Christmas period before rallying slightly, but there was a marked decline in his health from 6 January 2009 onwards. Between 9 and 12 January, he was in an increasing amount of pain.

53. The man died in his cell in the healthcare centre on 13 January 2009. Two staff nurses went into his cell at just after 3.40pm and noticed that his breathing was very shallow. They were aware that he did not want to be resuscitated and remained with him. He stopped breathing at 3.50pm, and the nurses could find neither a pulse nor a heartbeat. The first nurse asked a colleague to come to the cell and they agreed that the man had died.

54. The Head of Healthcare was told by telephone of the man's death at 3.55pm. Shortly after 4.00pm, his cell was locked and the local doctor on call was asked to come and certify death. At 4.20pm, the other prisoners in the healthcare centre were told that the man had died. Twenty minutes later, the Head of Healthcare, the Governor and a representative from the Independent Monitoring Board (IMB) arrived.

55. The on call doctor arrived at the prison at 5.05pm. A nurse brought him to the healthcare centre, and the padlock was removed from the man's cell at 5.10pm. Within a minute or two, the on call doctor confirmed death and the

cell was once again secured. About ten minutes later, the Head of Healthcare telephoned the man's brother to inform him that his brother had died.

56. Police officers visited the healthcare centre just after 7.00pm. (The police are always required to attend when a prisoner dies.) They left a few minutes later after viewing the body. The man was taken out of the prison just before 8.30pm. A debrief for all staff who dealt with his death was held on the following day.

57. Before the man died, he wrote individual letters to members of the healthcare staff. These letters, which expressed his appreciation of the care he had been given, were opened by staff after he had died. The man's funeral was held at St Mary's Roman Catholic Church in nearby Leyland. His family lived some distance away and were unable to be there, but the healthcare staff from Garth attended.

ISSUES

The delay beginning treatment

58. The man was first referred for treatment by a doctor at the prison on 27 November 2007. He underwent a series of tests across the New Year period which seem to have been concluded by 17 January 2008. However, the man was not assessed by a cardiothoracic surgeon until 12 March. He was then listed for surgery and underwent an operation on 31 March. Over four months had passed since the doctor referred him.

59. The cancer waiting time targets set out in the NHS cancer plan say that the first treatment of a patient's cancer must begin within two months (62 days) of an initial referral from a doctor. Treatment must start within one month (31 days) of the patient being diagnosed (this is referred to as the date when the decision is made to treat the individual). On this basis the man's initial treatment failed to meet NHS targets.

60. The investigator asked an Associate Director at Central Lancashire PCT to comment upon the delay. She accepted that targets had not been met and provided the following response:

> 'It would appear that the breach in achieving the 62 day treatment target was mainly the result of this being a complex diagnostic pathway requiring a number of diagnostic procedures to confirm lung cancer staging.
>
> 'This is often a cause of delays in first treatment for lung cancer patients as surgery is not undertaken unless there is no evidence of metastatic spread.
>
> 'In addition Christmas fell in the diagnostic/staging part of pathway which probably had some effect [on the delay].
>
> 'It should also be noted that the man did not attend an appointment at Blackpool Victoria Hospital on 13 February 2008 and was subsequently offered another appointment at the clinic on 12 March, which he attended.
>
> 'It is my understanding that the prison requested at least two weeks notice prior to his admission for surgery and he was subsequently admitted on the 30 March.
>
> 'The failure to attend the appointment on 13 February and the prison's insistence on two weeks notice of admission after he was seen on 12 March further extended the time taken from diagnosis to surgery.'

61. Although it is not within the Ombudsman's remit to comment on the care offered by the PCT, they have acknowledged the failure to meet targets in this instance. Given the Associate Director's comments, I make the following recommendations to the prison in the hope that lessons can be learned in the future:

    The Governor and the Head of Healthcare should consider whether a more flexible approach to the admission of a prisoner for planned surgery could be adopted to ensure that they are operated on as swiftly as possible.

    The Governor and the Head of Healthcare should ensure that patients with a diagnosis of cancer are always escorted to scheduled hospital appointments.

The failure to provide chemotherapy treatment

62. The man first showed symptoms of lung cancer in November 2007. He underwent a series of tests in the next few months and surgery took place on 31 March 2008. Following the operation, a consultant oncologist at the Rosemere Cancer Centre in Preston planned to treat the man with chemotherapy.

63. Before the man's chemotherapy could start, a consultant oncologist asked a consultant general surgeon to assess a potentially malignant thyroid condition which had also been detected. Whilst the consultant general surgeon completed his examination, the scheduled chemotherapy treatment was put on hold. On 16 May, the consultant general surgeon decided that the chemotherapy to treat the man's lung cancer should take priority, and that the slow growing growth on the thyroid gland could be managed once this course of treatment had been completed.

64. The prison received three different letters regarding the man's proposed course of chemotherapy on 7, 16 and 19 May. All three letters made clear the intention to start this treatment. The first stated that the man was anxious to start chemotherapy in the next few weeks. However, none of the letters confirmed when the treatment would begin.

65. In the following weeks, no chemotherapy sessions were scheduled by the hospital, and no further letters were sent to the healthcare team at the prison. The man's medical record indicates that he told the prison doctor that he was awaiting an appointment on 14 July. There is no evidence that his query was followed up with the hospital.

66. On 6 August, the man raised concerns with the healthcare team that he had still not undergone chemotherapy. The staff acted quickly at this stage to secure an appointment with the specialist at the hospital, and the man attended an appointment on 8 August. He was told by a locum oncologist (whilst the consultant oncologist took maternity leave) that the window of

opportunity for chemotherapy to take place following surgery had now passed. The proposed treatment was therefore not pursued.

67. The man underwent a CT scan on 2 September, which indicated that the cancer had not returned. However, he was admitted to hospital later that month and it was found that the cancer had spread to his brain.

68. A clinical review of the care the man received was completed. The author could find no evidence of the hospital sending the healthcare team at the prison a definite appointment for the man to start his course of chemotherapy. He did identify the failure of the prison doctor to follow up on the concerns the man expressed in mid-July. He found that 'swift action' had been taken by other healthcare staff at the prison when the man again complained on 6 August.

69. The clinical reviewer considers that responsibility for the failure to provide the chemotherapy treatment lies principally with the hospital. It is not within the remit of my investigation to assess any failure on the part of the Rosemere Cancer Centre. However, it would seem that the obligation lay with specialists at the centre to organise the course of chemotherapy and to offer an initial appointment for treatment.

70. An incident review concerning the man's death prepared for Lancashire Teaching Hospitals NHS Foundation Trust by the general manager of their oncology department has established the reason for the delay to the chemotherapy treatment. It found that an error occurred when the man was referred to the consultant general surgeon by the consultant oncologist in early May to have his thyroid condition assessed.

71. A chemotherapy booking form had been completed on 2 May and had been sent to the Chemotherapy Support Team, who schedule appointments. However, the consultant oncologist's secretary then notified the chemotherapy department to put his treatment 'on hold' until the consultant general surgeon had made a decision regarding the malignant growth on the man's thyroid gland.

72. On 16 May, having spoken with the consultant general surgeon, the consultant oncologist decided that chemotherapy should proceed. She thought that her secretary would communicate this decision to the chemotherapy team and an appointment would be made. However, this did not happen. Either the message was not given to the chemotherapy support team or it was not recorded and implemented by them. The consultant oncologist went on maternity leave on 25 July.

73. In August, the Chemotherapy Support Team was contacted by the consultant oncologist's secretary who said the prison had telephoned her to ask when the appointment would take place. At this point, it became apparent that an error had occurred and an appointment had not been made. The booking form was still in the 'on hold' tray.

74. The incident review concludes that a breakdown in communication between the consultant oncologist, her secretary and the Chemotherapy Support Team caused the delay in the man's chemotherapy treatment. The review highlights a need to clarify who is responsible for the various stages of the referral process and to improve the way it works so that a similar error does not occur in the future.

75. I concur that the failure to offer the man's chemotherapy treatment was principally the fault of the hospital. They were supposed to deliver the treatment, and wrote letters indicating that the planned chemotherapy was imminent. In a letter to the healthcare team at Garth dated 11 August (following the man's raising of the issue and return to hospital) the locum oncologist apologised for the 'miscommunication' that had taken place and seemed to accept that there had been a failure on the part of the Rosemere Cancer Centre.

76. Whilst I consider that the bulk of the responsibility for ensuring that the man received treatment lay with the hospital, I believe that some initiative might have been taken by the healthcare team at Garth to pursue the proposed chemotherapy. The incident review completed for Lancashire Teaching Hospitals found that one of the reasons nothing was done was that nobody queried the delay. No action appears to have been taken by the healthcare team until the man himself alerted them on 6 August. This was despite the fact that three letters had been sent in May confirming the intention to start chemotherapy, and that he was known to have been recently operated on as a patient with lung cancer.

77. This issue has arisen twice before. During the Ombudsman's investigation of the death of a prisoner in September 2006 (published in July 2007), he recommended that healthcare staff should note the contents of hospital correspondence to ensure that any follow-up outpatient appointments were attended. Similarly, the investigation into the death of a prisoner in December 2007 (published in October 2008) led the Ombudsman to recommend that the healthcare team should clarify whether they or the hospital should take responsibility for the progression of a prisoner's treatment. On that occasion there were delays referring the prisoner to the appropriate specialist because it was not clear who would coordinate his care and follow up the outpatient appointments.

78. When she spoke with the investigator, the Head of Healthcare said that her team had assumed that the Rosemere Cancer Centre would get in touch when they were ready to offer the man an appointment. The Head of Healthcare said that the man had gone back to work, moved back onto the wing from the healthcare centre and had not really complained until he enquired about his chemotherapy treatment in August. (Although, as I have already highlighted, the man did tell a doctor that he was awaiting a hospital appointment on 14 July, but this information does not appear to have been acted upon.)

79. The healthcare team at the prison do not appear to have reviewed the man's condition or to have followed up on the proposed treatment between May and August. The Head of Healthcare commented that gaps between surgery and subsequent chemotherapy can occur, and that not all chemotherapy immediately follows surgery. She therefore told my colleague that she would not have expected her staff to query the progress of the treatment, but would instead have expected them to wait for the specialist at the hospital to get in touch. However, the discussion that the man had with the doctor on 14 July could have provided an opportunity for the healthcare team to question the failure to begin chemotherapy.

80. I consider that the healthcare team could have taken a more proactive approach in checking on the progress of the man's treatment. He had recently been operated on, and the intention to begin chemotherapy had been repeatedly stated in correspondence. It seems reasonable to expect that staff might have made a telephone call to the specialist at the hospital, or might have reviewed the man's file at some stage. This is particularly important in the case of a prisoner because they are not at liberty to pursue their treatment in the same way as a member of the public. All communication has to go through the healthcare team.

81. The clinical reviewer believes that the 'regrettable' delay in starting chemotherapy might have been noticed by healthcare staff at the prison if the 'Outpatients Referrals and Appointments' register in the man's medical record had been properly completed and kept up to date. If it had been, it is possible that staff would have noticed the absence of chemotherapy appointments.

82. It is difficult to know the effect that the failure to provide chemotherapy had. The delay meant that the man missed the window of opportunity and was no longer in a position to undergo this treatment without a further scan being performed. The CT scan at the start of September (scheduled once the failure to deliver chemotherapy had been recognised) gave no cause for concern, but just three weeks later the cancer had spread to the man's brain and his prognosis was extremely poor.

83. I am concerned by the failure of staff at the Rosemere Cancer Centre and (to some degree) the prison healthcare team to ensure that the man received the correct treatment. I am disappointed that this is the third time the Ombudsman's office has highlighted similar problems with regard to patients accessing outpatient appointments at Garth. I endorse a recommendation made by the clinical reviewer, and make one further recommendation in this regard:

    The Head of Healthcare should ensure that a prisoner's future outpatient appointments are recorded in their notes.

    The Head of Healthcare should ensure that the ongoing treatment of any prisoner with a diagnosis of cancer is reviewed on a monthly basis to ensure that any proposed treatment such as chemotherapy is not overlooked.

Error administering medication

84. The clinical reviewer highlights an error made by a nurse. She gave the man twice the prescribed dose of oral dexamethasone by mistake at about 8.30am on Sunday 7 December 2008. The error was immediately recognised. The nurse told her line manager and made comprehensive entries in the man's medical records.

85. The healthcare team telephoned the National Poisons Information Service (NPIS) in Cardiff at about 11.30am to seek advice regarding the mistake. They also contacted the local on-call doctor (who was familiar with the prison having regularly held surgeries at Garth). Both the doctor and the NPIS advised that the man's condition should be monitored for the next 24 hours, but indicated that no serious side effects were anticipated. This was a drug that the man was due to be given, but the healthcare nurse administered an excessive amount of it. The Head of Healthcare has confirmed that an incident form was completed.

86. The next day, 8 December, the prison pharmacist and the Head of Healthcare were informed. The latter told the investigator that she completed the necessary paperwork and told her own line manager about the mistake. She said that she completed an incident reporting form and sent it to the local PCT.

87. The PCT was actually unaware of the error until the clinical reviewer and the Ombudsman's investigator brought it to their attention. There is no record of the PCT ever receiving the incident reporting form and the healthcare team have been unable to locate the original document. The PCT has therefore not yet either investigated this error or taken any action against the healthcare nurse. No formal action was taken against her at the prison. I understand that an electronic incident reporting system has been introduced since the form went missing, which will hopefully reduce the likelihood of this happening in future.

    Central Lancashire Primary Care Trust should satisfy themselves that the error made by the healthcare nurse has been dealt with appropriately.

Record keeping

88. The clinical reviewer praises the generally high standard of the documentation of the man's care. He commends the thorough planning involved and the largely careful recording of the progress of the treatment the man was offered. I note however that there are no entries in his records between 12 December 2007 and 4 February 2008. During this two month period, the man was undergoing a variety of tests to diagnose his cancer and made regular visits to the hospital. I am concerned that more comprehensive entries were not made, reflecting the progress of the man's condition.

A full account of a prisoner's visits to hospital and the outcomes of any tests should be kept in their medical record.

89. The use of some slang words in the man's medical records is criticised by the clinical reviewer and he makes the following recommendation, which I endorse:

The use of informal language when completing a patient's medical records should be avoided.

CONCLUSION

90. Aside from the failure to proactively enquire about the proposed chemotherapy treatment, the investigator has found much to praise with regard to the care the man received, particularly in the last four months prior to his death. The clinical reviewer also praises the care which staff delivered whilst the man was dying.

91. The clinical nurse specialist manager from St Catherine's Hospice who helped to oversee the man's treatment in the last few months of his life told my colleague that she was extremely impressed by the standard of care she witnessed being given by the staff. She said that St Catherine's Hospice is continuing to work with both Garth and HMP Wymott to develop the care that is offered to terminally ill patients. The Head of Healthcare said that the man was the first palliative care patient that staff had to manage at Garth. She commented that her team had learnt valuable lessons from the care they were able to give him.

92. The investigator spoke with one of the other prisoners in the healthcare centre who praised the level of care offered to the man. The man's brother has written a letter to the healthcare staff thanking them for the way they looked after the man. The Head of Healthcare said that staff had been greatly affected by his death. The man left individual notes for them, indicating that they had established a good rapport. His death seems to have had a significant impact on staff, but I understand that they were properly supported by the care team immediately after the man died. The healthcare team also showed their respect for him by attending his funeral.

93. I commend the decision not to cuff the man during his second prolonged stay in hospital in September 2008. He was frail and his dignity could be maintained without placing the public at risk. Both the Head of Healthcare and the Governor showed commendable consideration for the man's declining health. In particular, I am impressed by their willingness to let the man die at Garth rather than move him to HMP Preston, and their decision to keep the man in an unlocked cell in the healthcare centre. The man's family lived some distance away and he had no partner or children. His good relationship with the healthcare staff was therefore particularly important to him.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should consider whether a more flexible approach to the admission of a prisoner for planned surgery could be adopted to ensure that they are operated on as swiftly as possible.

   The prison accepted the recommendation. The Head of Healthcare has agreed to develop a clinical treatment plan in liaison with the Governor to ensure that planned interventions occur in a timely manner.

2. The Governor and the Head of Healthcare should ensure that patients with a diagnosis of cancer are always escorted to scheduled hospital appointments.

   The prison accepted the recommendation. It is agreed that either the Head of Healthcare or the Primary Care Lead will review all outpatient appointments for the forthcoming week. The Head of Healthcare confirmed that patients referred for treatment under the NHS's two week rule will not have their appointments cancelled. Any appointments at outside hospital that are cancelled will be discussed at the Prison Clinical Governance meeting.

3. The Head of Healthcare should ensure that a prisoner's future outpatient appointments are recorded in their notes.

   The prison accepted the recommendation. The Head of Healthcare, in liaison with the Practice Manager, agreed to introduce a system and to train administration staff to ensure that every new outpatient appointment is immediately entered onto the patient's electronic medical record. Patient records will be audited to ensure compliance.

4. The Head of Healthcare should ensure that the ongoing treatment of any prisoner with a diagnosis of cancer is reviewed on a monthly basis to ensure that any proposed treatment such as chemotherapy is not overlooked.

   The prison accepted the recommendation. The Head of Healthcare attends a monthly meeting with St Catherine's Hospice (accompanied by the Primary Care Lead and the older people's nurse link) as part of the Palliative Care Network. Patients with a diagnosis of cancer or a life limiting illness are discussed at this monthly meeting as a matter of routine. All of these patients are maintained on a register in line with the National Gold Standards Framework.

5. The local Primary Care Trust should satisfy themselves that the error made by the healthcare nurse has been dealt with appropriately.

   The prison accepted the recommendation. The local Primary Care Trust has completed an investigation into the error in giving medication and their recommendations have been implemented.

6. A full account of a prisoner's visits to hospital and the outcomes of any tests should be kept in their medical record.

The prison accepted the recommendation. Letters from outside hospital are now scanned into the electronic patient medical record when the healthcare department receives them. Treatment plans and any follow up documentation from outside hospital visits which are brought back by the escorting officers are to be kept in the patient's medical record. Clinical records will be audited to ensure compliance

7. The use of informal language when completing a patient's medical records should be avoided.

   The prison accepted the recommendation. An abbreviation list has been devised and placed in the front of every patient's medical record. Record keeping training will be provided for healthcare staff. Clinical records will be audited.

THE RESPONSE OF THE FAMILY TO THE DRAFT REPORT

The man's brother was provided with a copy of the draft report. He has not been in touch with the Family Liaison Officer to respond to the findings and recommendations.