

**The death of a man, who was a prisoner at HM Prison Highdown,  
on 31 October 2005**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**July 2006**

This is the report of an investigation into the death of a man who was a prisoner at HM Prison Highdown. The man, who was aged 44, died on 31 October 2005 at the Royal Marsden Hospital. The cause of death was recorded as a squamous cell carcinoma of the tongue. The man had been diagnosed with terminal cancer in April 2004.

Unfortunately, the man was estranged from his family and none of his relatives has been traced. Nevertheless, I take this opportunity to offer my sincere condolences to all of the man's friends and to all of those touched by his loss.

The investigation was carried out on my behalf by one of my investigators. An independent review of the man's medical care in prison, for which I am most grateful, was carried out by a panel on behalf of the East Elmbridge and Mid Surrey Primary Care Trust. I would also like to thank the Governor and staff of HM Prison Highdown for their full and ready co-operation during the investigation.

As with many of my investigations following a death from natural causes, my findings are strongly influenced by the clinical review. In the case of this man, the reviewers from East Elmbridge and Mid Surrey PCT judge that the level of care he received was far from satisfactory. It appears no package of health and social care was put in place to meet the man's needs. There was no cancer care pathway or, indeed, much thought about how best to meet the needs of a terminally ill patient. There are significant lessons here, therefore, for the Governor and Healthcare Manager.

My report was sent in draft to the Governor of Highdown. I have received a number of comments from the prison in response, and I have included these in the text where appropriate.

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

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**July 2006**

## **Contents**

1. Summary
2. Investigation methodology
3. Background
4. HM Prison Highdown
5. Events prior to the man's death
6. Consideration of issues arising from the investigation
7. Recommendations

## 1. Summary

The man who died was initially remanded in custody to Highdown in September 2003. He was convicted and sentenced to four years imprisonment in the spring of the following year. At his first reception health screening, the man reported that he had previously suffered from heart problems and had had an operation for arthritis.

In January 2004, the man reported that he had bitten the left side of his tongue. This ulcerated and he subsequently underwent a biopsy. The results of this indicated a cancerous tumour of the tongue. The man underwent surgery to remove the tumour on 15 June. This was a success and he did not therefore require post-operative radiotherapy.

The man was reviewed regularly in the following months, and each time he was given the all clear. However, he began to complain of discomfort in the left side of his neck in June 2005 and, following a scan in late July, was diagnosed with a further tumour. Subsequent analysis led to the conclusion that removal by surgery was inadvisable on this occasion. The man was subsequently informed that treatment would involve chemotherapy and radiotherapy. He also started a course of Oramorph at this time to control the significant pain that he was experiencing. (Despite the pain, the man declined admission to the Healthcare Centre at Highdown on a number of occasions.)

His course of radiotherapy was due to commence on 21 September at the Royal Marsden Hospital. However, the man did not feel comfortable wearing the plastic mask necessary to cover and support the head during radiotherapy, and he therefore refused the treatment. Nonetheless, he continued to receive the palliative care provided at Highdown.

The man's condition deteriorated further and he was admitted to the Royal Marsden on 4 October as an inpatient. He was discharged on 11 October and, on 17 October, was granted permission to keep Oramorph in his cell overnight due to the extreme pain that he was suffering.

On 12 October, the Parole Board agreed to the man's early release on licence. However, suitable release accommodation could not be found due to the nature of his offence and the difficulties this presented for insurance purposes. Furthermore, by the time of the Parole Board's decision, his condition had deteriorated significantly and he was not well enough to live in Approved Premises (a probation hostel).

The results of an x-ray on 28 October showed a growing lump, and the man was again admitted to the Royal Marsden as an inpatient. His condition deteriorated and he passed away on the morning of 31 October. The cause of death was recorded as a squamous cell carcinoma of the tongue.

The clinical review, conducted by the East Elmbridge and Mid Surrey Primary Care Trust, is very critical of a number of aspects of the nursing care that the man received at Highdown, and of the standard of medical record keeping.

I make six recommendations.

## **2. Investigation methodology**

The investigation was opened on 15 November 2005 when my investigator, visited Highdown and issued notices announcing the investigation and its terms of reference to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward to speak to my investigator.

On his initial visit to Highdown, my investigator met with the deputy governor and was given a tour of the prison. He was therefore able to familiarise himself with the Healthcare Centre and the wing on which the man had lived. He was also given access to the man's prison files, including the Medical Record.

An independent clinical review into the man's health needs whilst he was in custody at Highdown was carried out by a panel on behalf of the East Elmbridge and Mid Surrey Primary Care Trust.

One of my family liaison officers contacted one of the man's friends, who was his nominated next of kin, on 23 November 2005. His friend's view was that the prison had treated the man well. However, she added that the man had been very worried about where he was going to live when he came out on parole.

The report was sent to the man's nominated next of kin and the Prison Service in draft. Their comments have, where appropriate, been reflected in the text.

### **3. Background**

The man was born in 1961, and was 44 years old at the time of his death. At the time of his first reception into prison, the man was recorded as being unemployed.

He was not a heavily convicted man. In 1980, he had been convicted of causing grievous bodily harm and in 1983 he was convicted of theft. He received non-custodial sentences for both offences. He was then clear of trouble until September 2003 when he committed an offence, seemingly under the influence of a combination of temazepam (a prescription drug used to treat insomnia) and whisky. The man was remanded in custody to Highdown on 30 September 2003, before being convicted on 19 February 2004. He received a sentence of four years imprisonment on 2 April 2004.

#### **4. HM Prison Highdown**

Highdown prison, on the outskirts of Sutton in Surrey, first opened in September 1992. It is a local prison holding both remand and convicted prisoners. The prison consists of four houseblocks, with a mixture of single, double and treble occupancy cells. The total capacity is 736.

Healthcare is provided by the East Elmbridge and Mid Surrey Primary Care Trust. The Healthcare Centre, which is operated by both nurses and healthcare officers, has an in-patient capacity of 23 beds in single cells.

The most recent report from HM Chief Inspector of Prisons, dated November 2004, reported a significant improvement in the provision of healthcare services at Highdown. However, there was concern at the high number of prisoners who failed to attend healthcare appointments.

## **5. Events prior to the man's death**

When he was first remanded into custody on 30 September 2003, the man reported at his first reception health screening that he had previously suffered from heart problems and had had an operation for arthritis. He also said that he was suffering from depression and that he had attempted to kill himself in the past. A suicide and self-harm monitoring form (F2052SH) was raised.

As well as the opening of the F2052SH, the man was admitted to the Healthcare Centre so that he could be monitored more closely. He complained of thoughts of suicide and anxiety pre-dating his time in custody, and said that being in prison had exacerbated the situation.

He was originally placed on a 15 minute watch. However, the man began to come to terms with his situation and was taken off the watch on 5 October and subsequently relocated to a houseblock on 14 October. At a case review on 23 October, the man reported that he had no thoughts of self-harm or suicide and, when these sentiments were repeated at his next case review on 30 October, his F2052SH was closed.

In January 2004, the man reported that he had bitten the left side of his tongue. There is no evidence that this was done deliberately. He sustained a laceration which ulcerated, and was subsequently referred to a consultant oral surgeon at a nearby hospital. The problem persisted and, on 29 April, the consultant oral surgeon arranged for an urgent biopsy. The results, one week later, indicated a diagnosis of a moderately differentiated squamous cell carcinoma (a cancerous tumour of the tongue). The man was informed of the diagnosis and the need to remove the tumour by surgery with the possibility of follow-up radiotherapy.

Surgery was arranged for 15 June 2004 at a major London hospital. This involved the removal of the tumour, along with a left neck dissection which was reconstructed with a flap from the man's right arm. The surgery was a success, with the tumour fully removed, and the man did not therefore require post-operative radiotherapy. However, in the weeks after surgery, the man complained of pain and stiffness in his left shoulder, and was therefore started on a course of physiotherapy.

The man was reviewed regularly in the following months, and each time he was given the all clear with no sign of recurrence. In June 2005, he began to complain of discomfort in his left neck and, following an examination at the Head and Neck Clinic at the hospital on 30 June, it was confirmed that a firm mass was present. He underwent a CT scan in late July and the result of this and a fine-needle aspiration (an analysis of cells extracted using a needle) confirmed a further squamous cell carcinoma on the left side of his neck. Further analysis concluded that the site and size of the mass made removal by surgery inadvisable, and the man was therefore informed that treatment

would involve chemotherapy and radiotherapy. In the interim period, the man started a course of Oramorph to control the significant pain he was experiencing in his neck.

On 20 July, the man raised a formal complaint regarding the issuing of his medication. His complaint was that he should be allowed co-codamol (he mistakenly referred to this as co-codeine in his complaint form), a painkiller, in his possession so that he could take it as required at 9am, 2pm and 8pm. In response, the Head of Healthcare informed him that all codeine based medication is supervised at Highdown. However, she recommended that he spoke to the Houseblock Nurse to arrange a more suitable time for his dosage.

On 23 August, the man was referred to a hospice near the prison, for specialist palliative care by a prison GP at Highdown. The referral highlighted pain control as a current problem. The man was visited on 26 August by a member of the Community Palliative Care Team at the hospice. Adjustments were made to the administration of his analgesia. It was also agreed that the man could telephone the member of the Community Palliative Care Team on a daily basis to discuss his treatment.

Despite the pain that the man was experiencing, he declined admission to the Healthcare Centre at Highdown on a number of occasions in August and September. He said that he preferred to remain on the houseblock so that he could continue to attend education classes and because the Healthcare Centre was too noisy and had no television.

On 19 September, the man collapsed whilst on the houseblock after suffering a dizzy spell and was admitted to the Healthcare Centre as an inpatient. Despite continuing to suffer severe pain, he maintained throughout his stay in Healthcare that he did not want to be there and was, at times, aggressive and abusive towards Healthcare staff. No further episodes of dizziness were recorded and, after being seen by a doctor, the man was discharged and returned to the houseblock on 20 September.

The man's courses of radiotherapy and chemotherapy were scheduled to commence on 21 September at the Royal Marsden Hospital, a specialist cancer hospital. The planned schedule of treatment was daily radiotherapy for six weeks, with chemotherapy in the first and fourth weeks. However, the man did not feel comfortable wearing the plastic mask that covers and supports the head during radiotherapy, saying that it made him feel claustrophobic and panicky. Despite attempts to minimise the restrictions imposed by cutting out parts of the mask, he continued to complain of discomfort and refused to accept the treatment. However, he was willing to continue receiving the palliative care provided at Highdown.

On 26 September, the prison GP contacted the hospice with regard to admitting the man for a short stay for further palliative treatment. This was agreed in principle by both the prison and the hospice. However, as he was receiving frequent treatment at the Royal Marsden, it was later decided by the

member of the Community Palliative Care Team and the prison GP that his palliative care would not benefit from admission to a hospice.

The man continued to decline treatment and refused to attend hospital appointments on 30 September and 3 October. It was arranged to admit him to the Healthcare Centre as an inpatient on 30 September but, on arrival, he was verbally abusive to staff and refused to stay. He subsequently left the Healthcare Centre before his admission could be completed.

As well as the constant neck pain he was suffering, the man was now having difficulty swallowing. Given the deterioration in his condition, he was admitted to the Royal Marsden Hospital as an inpatient on 4 October. He was discharged from the Royal Marsden on 11 October and returned to houseblock 2 at Highdown. By 17 October, the man's swallowing had deteriorated considerably and he was now unable to eat normal meals, taking nourishment drinks instead. On the same day, he complained that he felt pain in the morning and requested permission to keep Oramorph in his cell for use in the mornings. This request was granted.

On 12 October, the man was found suitable for early release on licence by the Parole Board. The Board remarked on how he had shown remorse for his offence. A Parole Clerk at Highdown, contacted a number of different organisations to try to find suitable release accommodation for the man, including the St Giles Trust, the local council, and the Salvation Army. She said at interview that the major barrier to finding accommodation for the man was the nature of his offence and the difficulty it presented for the insurance cover of the premises that might take him. Moreover, by the time he was granted parole, the man's condition had deteriorated significantly and he was not now well enough to take a place in hostel-type accommodation.

On 22 October, the duty nurse was called to the man's cell at 4.45am as he was reported to be coughing up blood. The man said at the time that he felt generally fine, but was worried about the blood. He made no complaints about being in pain. He was assessed by a doctor later that morning. The doctor recorded that his appearance was normal. An appointment was made for the man to have a chest x-ray on 24 October.

The resulting x-ray was seen at the Royal Marsden on 28 October when the man attended for a scheduled appointment. An assessment of the x-ray revealed a growing lump, and it was therefore decided to admit him for immediate treatment. His condition deteriorated over the weekend and the man passed away on the morning of 31 October. Death was pronounced at 8.45am.

The man's friend and nominated next of kin was informed of his death over the telephone by the Head of Residence at Highdown. The Head of Residence did not recall the time at which he spoke to the man's friend, but said it was as soon as he could make contact with her. The man was cremated on 11 November in a service conducted by the chaplain and arranged by the chaplaincy.

## 6. Consideration of issues arising from the investigation

### *Quality of care provided at Highdown*

The clinical review, conducted by the East Elmbridge and Mid Surrey Primary Care Trust, is very critical of the quality of nursing care that the man received at Highdown. In particular, the review highlights a “distinct absence of nursing intervention throughout the man’s recorded illness”. For instance, the review notes that, when he complained of extreme pain and a lack of appropriate pain control, no entries were made in his Medical Record by nursing staff and care plans were not commenced. Indeed, the reviewers say they found “no evidence of relevant care plans throughout his stay in prison”. Other examples noted in the review include the non-recording of the man’s weekly weights and nutritional status, and a lack of communication between healthcare staff and hospitals. The review concludes that this has “led to a complete breakdown in a care pathway that should have been evident for a man with an initial and subsequent terminal illness”.

The review is critical of the man’s ‘equitable care’ (the extent to which a prisoner’s medical treatment is the equal of that which would be expected in the community), providing numerous examples where equity of care was not achieved. It highlights that on 22 August 2005 Oramorph was suggested for the man’s pain control. However, it notes that whilst there was an expectation that nursing staff were able to titrate the dosage to gain maximum effect, “the current staff do not have this competency”. On the same date, the review notes that Gabapentin was commenced, yet some doses were missed “with a detrimental effect on the man’s pain control” and “the nursing staff should have ensured that there was a sufficient supply of the drug for this man”.

The review also criticises Highdown’s use of the Emergency Nurse Practitioner (ENP) who was available on site. The ENP had the expertise to deal with palliative care and to provide continuity of care, as well as to support and educate both the man and the nursing staff. The review notes, however, that she was under utilised as a resource.

Communication between healthcare staff at Highdown and hospitals pre and post operatively is also found wanting in the clinical review. It identifies no clear pathway for feedback to healthcare staff following outpatient attendance, and no clear pathway for prisoners requiring palliative care intervention. The review says that “inadequate communication between the prison healthcare service and the hospitals had a potentially detrimental affect on the care this gentleman received”.

**The Healthcare Manager, in partnership with the Primary Care Trust and local secondary care providers, should agree and implement information sharing protocols to ensure appropriate and timely patient care with the multi-disciplinary team and the external health and social care partners.**

**A local care planning strategy, which includes pathways of care, care planning, review and evaluation, must be developed and audited to ensure effective communication within the multi-disciplinary team.**

**The Healthcare Manager in partnership with the PCT should develop a locally agreed communication pathway to maximise the prisoner/patient's health and social care.**

**The Healthcare Manager should undertake a training needs analysis to review the training needs of healthcare staff.**

I have received the following comments in response to this criticism from Highdown:

“A clinical review is solely based on the medical record. Regrettably nursing and medical staff had omitted to record large sections of the man's care so there is little/no physical evidence but this does not mean that good care was not provided. In fact nursing staff spent considerable time with the man to ensure that his needs were addressed especially psychological aspects of his care”.

“Letters of referral from HMP High Down to the secondary care sector always happen. This is often combined with a telephone call in the case of emergencies. It is rare however for local hospitals to provide discharge summaries or feedback following attendance. Usually healthcare staff at the prison telephone to speak to the appropriate clinician and we ask for a fax.....There is no difficulty with sharing medical information on a 'need to know' basis for continuity of care, but some individual clinicians within Secondary Care just do not communicate”.

“A training needs analysis is undertaken every year since 2003, also a skill mix review. However, funding is an issue. Training needs can be identified but it can not always be delivered. Every opportunity is taken to deliver training on site”.

### ***Quality of record keeping at Highdown***

As well as noting the absence of records of the man's pain control, and of care plans, the clinical review highlights numerous gaps in the clinical records around the time of his surgery. There was also a lack of entries regarding hospital appointments, admissions and their outcomes. The standard of completion of the medicines charts was described as unacceptable. Furthermore, the man's weekly weights were not recorded as requested, nor his nutritional status.

**Staff should be reminded of their professional responsibilities to ensure appropriate and effective record keeping in accordance with the standards laid down by the General Medical Council and Nursing and Midwifery Council. The Healthcare Manager should consider the**

**introduction of mandatory training to ensure that staff comply with these responsibilities.**

**A system of clinical audit must be developed to enable the monitoring and compliance with agreed standards of record keeping. This should form part of local clinical governance arrangements.**

I have received the following comments in response from Highdown:

“Clinical audit is established. The Healthcare Commission carried out an audit of medical records on October 2005. Follow up audits have been completed. On a recent visit by HMCIP and the Healthcare Commission there were no areas of concern raised regarding notes selected at random. Considerable work has been done in the last nine months to raise the standards of record keeping. Clinical audit is an agenda item on the Clinical Governance committee, which is held every 2 months”.

### ***Medication***

It is of concern that appropriate arrangements are not in place to ensure the administration of medication in accordance with clinical recommendations and patient need. I appreciate that on occasions codeine-based medication can be used as a currency by prisoners. However, to deny a terminally ill patient access to appropriate pain relief is unacceptable.

In the later stages of his care, arrangements were made for the man to have access to Oramorph overnight. This action is commendable. However, the response to the man’s complaint in July 2005 was not acceptable, and alternative arrangements should have been made to ensure that he did not experience the pain he did.

I have received the following response from Highdown:

“In July the man was not terminally ill, he was vulnerable. The policy of codeine based medication is not just about reducing the risk of prisoners trading drugs, but also to protect vulnerable prisoners from having their medication stolen from them. When the man needed to have Oramorph throughout the night he was in a single cell. He received his individual dose containers of Oramorph after other prisoners were locked up and he was allowed out of his cell before other prisoners in the morning so that un-used bottles could be returned to healthcare. This was for the safety of the man.”

### ***The allocation of accommodation to the man outside of Highdown***

During a telephone conversation with one of my Family Liaison Officers, the man’s next of kin said that he was very worried about where he would live after he came out on parole. In granting the man parole on 12 October 2005, the Parole Board made a condition that he was to live in Approved Premises (a probation hostel), unless it was necessary for him to go into hospital. The

Board placed no further restrictions on his accommodation, other than that he was not to enter a defined area of a large town.

In the weeks leading up to the man's consideration by the Parole Board, a Parole Clerk at Highdown contacted a number of organisations in an effort to find suitable accommodation for him. However, as noted, there were problems in finding such accommodation. The Parole Clerk therefore also consulted a number of organisations who would not normally be contacted over such matters, including the Salvation Army. Discussions were also held with a nearby hospice, with a view to admitting the man as an inpatient for symptom control. However, as he was receiving frequent treatment at the Royal Marsden Hospital, this was not deemed to be required.

It is of concern that more effort to identify suitable accommodation was not made by healthcare, either by supporting the Parole Clerk or making their own enquiries. It is unclear why a decision was taken that the man was not suitable for hospice care. However, other alternatives such as nursing homes should have been considered.

I consider the time and effort that the Parole Clerk put into finding suitable accommodation to be commendable, and draw attention to this as an example of good practice.

Highdown has provided the following comments in response:

"The establishment has tried to arrange nursing home accommodation in the past but this has to be done through the Continuing Care process. It is actually quite difficult to arrange nursing home placement for prisoners. The last time it took (the) healthcare manager 6 months. This was because nursing home owners are worried about taking ex-prisoners into their home as they might pose a risk to other residents."

"The hospice would not be an option for long term accommodation. Beds are limited and demand is high. If he was not under the care of the Royal Marsden then the hospice would indeed have been an option for respite and/or symptom control. This avenue was not followed, a decision made jointly between medical and hospice staff."

## **7. Recommendations and Good Practice**

### ***Recommendations***

The Healthcare Manager, in partnership with the Primary Care Trust and local secondary care providers, should agree and implement information sharing protocols to ensure appropriate and timely patient care with the multi-disciplinary team and the external health and social care partners.

A local care planning strategy, which includes pathways of care, care planning, review and evaluation, must be developed and audited to ensure effective communication within the multi-disciplinary team.

The Healthcare Manager in partnership with the PCT should develop a locally agreed communication pathway to maximise the prisoner/patient's health and social care.

The Healthcare Manager should undertake a training needs analysis to review the training needs of healthcare staff.

Staff should be reminded of their professional responsibilities to ensure appropriate and effective record keeping in accordance with the standards laid down by the General Medical Council and Nursing and Midwifery Council. The Healthcare manager should consider the introduction of mandatory record keeping to ensure that staff comply with these responsibilities.

A system of clinical audit must be developed to enable the monitoring and compliance with agreed standards of record keeping. This should form part of local clinical governance arrangements.

### ***Good Practice***

The time and effort that the Parole Clerk put into finding suitable accommodation for the man is commendable.