

**Investigation into the death of a man at HMP Altcourse
on 17 August 2006**

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

August 2007

This is the report of an investigation into the circumstances surrounding the death of a man on 17 August 2006. The man was diagnosed with terminal lung cancer whilst a prisoner at HMP Altcourse. He spent his last days in the healthcare unit and died as a result of his illness. He was 56 years old.

I extend my condolences to the man's family and to all those touched by his death.

The investigation was undertaken by one of my colleagues. Both my colleague and I would like to extend our thanks the Director of Altcourse, and his staff for their co-operation during the investigation. Particular thanks go to the prison liaison officer for gathering all relevant documentation and ensuring it was made available in a timely way. I would also like to thank Liverpool Primary Care Trust for carrying out a clinical review into the healthcare the man received at Altcourse.

The man had served 18 months of a long term sentence when he first began to present symptoms. Whilst he struggled at times to come to terms with his illness, and was resistant to a move from normal location to healthcare, it is clear that staff at Altcourse continued to support him physically and mentally as best they could. I am in no doubt as to the effectiveness of the palliative care he received, an observation I have made in a previous report where the Liverpool Care Pathway took responsibility for a prisoner's terminal healthcare needs.

I make four recommendations. I also commend Altcourse for putting arrangements in place to ensure the man's last few months were as dignified as possible. I make particular reference to a member of staff in healthcare and the action she took during his final hours of life and have highlighted this and other staff support as two examples of good practice. The clinical review found that the man received care of a similar standard to that he would have received in a community setting. As well as echoing a recommendation of my own on record keeping, the clinical review also highlights two areas of good practice.

**Stephen Shaw CBE
Prisons and Probation Ombudsman**

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SUMMARY

The man who died was arrested for a number of serious offences in December 2003. He was convicted and on 16 August 2004, was sentenced to nine years imprisonment. He had served two years of his sentence when he passed away during the early hours of 17 August 2006.

The man settled into prison life well. He found employment quickly and maintained a good work record. He also attended a number of courses and was showing encouraging signs of development throughout the early part of his sentence.

He first complained of feeling unwell in May 2006. His symptoms worsened and, following a number of visits to healthcare, he was sent to the local hospital for exploratory procedures. In July 2006, the man was diagnosed with terminal lung cancer. He spent two periods in hospital, but on 7 August he returned to the healthcare unit at Altcourse for the last time, under the care of the Liverpool Care Pathway and local district nurses.

The man spent a further 10 days in the healthcare unit and was cared for using the Marie Curie Hospice model of nursing adapted for use in a custodial setting. During the evening of 16 August, his condition deteriorated rapidly and he died peacefully at 2:50am the following morning. A member of the healthcare team was at his bedside.

THE INVESTIGATION PROCESS

1. The investigation was opened on 28 August 2006. My investigator obtained all relevant prison records including the man's medical and core records covering the two years he spent in prison.
2. Notices to staff and prisoners were supplied and displayed around the prison. These invited anybody with information to talk to my investigator. In this instance, no staff or prisoners came forward. My investigator examined the records and recorded significant events. From this evidence, she did not feel it necessary to visit Altcourse and no interviews took place.
3. A representative from Liverpool Primary Care Trust was invited to undertake a review of the clinical care the man received while in custody. The clinician's review is included as an annex to this report.
4. The Coroner was informed of the Ombudsman's investigation. The post mortem report recorded the cause of death as:

1a Metastatic Carcinoma of the lung

The Coroner will receive a copy of this report when it is completed to assist him with his enquiries.

5. The man's sister and daughter were contacted by one of my Family Liaison Officers to ask whether they or other members of the family had any comments or concerns about his death. The family raised no concerns and will receive a copy of my report.

HMP ALT COURSE

11. HMP Altcourse opened in December 1997. It is one of ten privately run establishments within the contracted prisons estate. It is managed by GSL UK Limited (formerly Group 4).
12. Altcourse operates as a local category B male prison. It holds both convicted and remand adults, and young offenders sent from the courts in Merseyside, Cheshire and North Wales. The prison has an operational capacity of 903 located in six main house blocks. The site also contains a modern healthcare centre, a rehabilitation unit, segregation unit, college and sports facilities.
13. Reynoldstown unit, where the man was located, houses sentenced prisoners wishing to undertake full time education courses, and vulnerable prisoners.
13. The most recently published inspection report by Her Majesty's Chief Inspector of Prisons, dated April 2005, describes Altcourse as "a very good local prison" which echoes the Prison Service's own evaluation of the prison as a high performing establishment. The HMCIP report found that Altcourse was performing well against its own *Healthy Prison* criteria of safety, respect, purposeful activity and resettlement.
14. HM Chief Inspector recorded that healthcare services at Altcourse, run by the privately owned Veritas company, maintained good links with the Liverpool Primary Care Trust (PCT). The Inspectorate's survey of prisoners conducted during the inspection scored healthcare well above the average for similar prisons.
15. The aim of the healthcare service at Altcourse is to treat the more minor physical and mental health needs of prisoners on normal location where possible. This means that only the most ill prisoners are generally admitted and cared for in the 24 hour manned healthcare centre. The inpatient facility has room for up to 12 patients in 10 single cells and one double cell.

KEY EVENTS

16. On the evening of 1 May 2006, the man was seen by the prison doctor on his medical rounds. He complained that he had been experiencing abdominal pain for a number of weeks and asked to be prescribed analgesia. The doctor advised him to make a doctor's appointment in the healthcare centre and gave him two paracetamol for the pain. He was also advised that, if his symptoms worsened, he was to return to healthcare in order for the doctor to see him the following morning.
17. The man was seen by the doctor again on 5 May and requested analgesia for a second time. A blood sample was taken and he was given paracetamol for pain relief. The doctor explained that he would have to wait for the results of the blood test. The man returned to his cell and spent an uncomfortable weekend on the unit. His medical records did not record the outcome of his blood tests.
18. He did not return to the healthcare centre until five weeks later. On 7 June, he was seen on triage and asked for a doctor's appointment. He also requested a change in medication and complained that the current prescription was having no effect. It is unclear from the records whether an appointment was made.
19. On 12 June, staff working on the man's unit informed healthcare that he was still complaining of abdominal pain and wanted to see a member of the healthcare team. When he arrived in healthcare he made the same complaint and added that, although he did not feel sick, he had experienced problems going to the toilet for approximately four weeks. The nurse made an entry in his medical record which explained that the man was already under investigation for gall stones and possible liver problems but that his abdomen was quite tense. He was advised to drink more fluids and to let healthcare know if the problem worsened overnight. No further action was taken as he was due to see the doctor the following day.
20. Between 13 and 18 June, the man was seen by the doctor on two more occasions. At his first appointment on 13 June, the doctor noted that he was experiencing severe upper abdominal pain. He was prescribed analgesia and more blood was taken for tests the following day. On 17 June during evening medication, he complained of chest pain and told the nurse it had worsened over the last couple of days. After he saw the doctor on 18 June, staff were advised to continue the analgesia until the doctor reviewed his condition in 10 days time.
21. However, between 22 and 25 June, nurses were called to the unit three times and noted that the man was still experiencing chest pains and muscular pains when lying down.
22. A nurse attended to the man on 22 June and noted that, despite being in pain, he was not unduly breathless or experiencing feelings of sickness. The doctor saw him the following day, reviewed his condition, and noted no

change to his medication. Another member of nursing staff was called to the unit on 24 June and found him breathless and in pain. The nurse administered oxygen and gave him some aspirin. The entry in his medical record stated that the pain seemed to be coming from between the man's ribs and eased when oxygen was given. He was seen by the doctor again the next day and his breathlessness was recorded.

23. During that same week, one of the nurses attempted to chase up the man's referral for a hospital appointment made by the prison doctor some weeks earlier. She was told a referral letter had been received on 14 May and there was a 14 week waiting list for an appointment. The nurse left the direct number for the hospital in his medical record and added that healthcare would continue to wait for the appointment.
24. A Registered Mental Health Nurse was once again called to the unit on 27 June. The man was displaying signs of breathlessness and was pale. The nurse established that he had been experiencing pain throughout the night and had tried to use a 'GT' spray, given to him by nursing staff the previous day, but to no effect. The nurse put out a 'Code One' emergency call and an ambulance was called. Whilst waiting for the paramedics to arrive, the nurse administered oxygen and the man's breathing became more regulated. His anxiety had decreased when paramedics arrived. He was taken to hospital for a check up.
25. Later that same day, two escorts accompanying him to the hospital contacted healthcare staff to update the centre on his progress. A nurse took the call and noted in his medical record that he had a blood clot and was waiting in the Accident and Emergency Department until a bed could be found to admit him to hospital. The man was expected to remain there for at least three days.
26. For the next three days, healthcare staff called the hospital for progress reports and recorded all the information shared about his condition. On the evening of 28 June, the man was moved to a ward following a CT scan. One of the nurses on duty that day was told that the most likely diagnosis was cancer of the lung but that, until the consultant saw him, nothing could be confirmed. The following evening, the same nurse called again and spoke to the staff nurse on the ward. The staff nurse confirmed that the man had now been given the results of his scan, but she refused to discuss any more detail over the phone and asked that healthcare staff speak to the consultant for more information. He remained comfortable and pain free and the staff nurse suggested a possible discharge in the next day or two.
27. The man was discharged on 30 June and returned to Altcourse. On arrival, he was taken straight to the healthcare centre and was told to remain there until the doctor could review his condition. At 3.30pm, the doctor visited him and put a stop to his heart medication as it was no longer necessary. His new medication was written up and administered. He was considered fit for normal location and was discharged from healthcare back to his unit.

28. For the next week, the man remained mostly in his cell. He was seen by a nurse on the morning of 5 July and complained that he been in pain all night. The man preferred being on his unit and explained that he had not wanted to call out night staff in case they admitted him to healthcare again. He was given his medication and by lunchtime the pain had subsided. A memo was sent to his unit manager to remind staff to transfer him to healthcare on 18 July in preparation for a hospital appointment the following day.
29. The man's stay in normal location did not last long. The following afternoon he was admitted to the healthcare centre and, on arrival, a nurse noticed he had developed a small pressure area to his right side. He was placed in bed, given oxygen and advised to sleep with the backrest on his bed in a fully extended position for more comfort. At 7.30pm, a nurse made an entry in his medical record which confirmed he had been given his medication and could have further medication for the relief of breakthrough pain.
30. On 7 July, the man was seen by a doctor in healthcare. The doctor noted that, although he seemed more comfortable than the day before, he was still experiencing left sided chest pain and had difficulty swallowing food. The man was given morphine for the pain and a soft diet was ordered from the kitchen.
31. He remained in healthcare for the next three days and saw the doctor every day as part of his routine morning rounds. Each time, the doctor monitored his condition and noted any spells of dizziness and breakthrough pain. The doctor changed his medication to help manage the man's pain and address the constipation he had begun to experience. He continued to ask if he could be returned to his unit and was assessed as fit for normal location by the doctor on 10 July. He returned to his cell later that day.
32. The two doctors who had continuously cared for the man, took the opportunity to write a memo to the Director of Altcourse. The memo, dated 12 July, set out his condition and explained that his illness was probably terminal. The memo further explained that, until a lung biopsy could be performed, neither doctor could be sure what future treatment the man would need, how frequently he would need it, or where the treatment was likely to take place.
33. He continued to experience pain over the next few days and nursing staff were called to the unit to attend to him. On each occasion, his condition was recorded in his medical record and medication for pain relief was administered. The man said that he was finding it increasingly difficult to cope with the pain and became distressed and anxious.
34. On 20 July, he was admitted to ward 15 at Fazakerly Hospital where he remained in a comfortable condition. The following day, a nurse contacted the ward for an update and was told his pain had yet to be fully controlled and, unfortunately, the hospital could not carry out a lung biopsy. The procedure was to be rescheduled.

35. The man remained in hospital for a further two weeks. During that time he was x-rayed, scanned, and underwent other exploratory medical procedures to determine the extent of his illness. Throughout his stay, healthcare staff contacted the ward for regular progress reports and kept in touch with escort staff on bedwatch duty. He remained in some pain and discomfort and continued to receive pain relief via a syringe driver. The nurse made entries in his medical record to confirm that both the healthcare manager and duty manager were fully aware of the man's situation, and were awaiting a discharge date from the hospital consultant.
36. On 7 August, the man returned to Altcourse under a Palliative Care Plan (PCP). He had been diagnosed with terminal cancer of the lung with secondary spread. The plan was comprehensive and covered pain management, appetite, mental health management, medication, district nurse visits and symptom control care. The nursing care and discharge pack from the hospital made clear to healthcare staff that he was to be placed on a syringe driver to control the pain and was to be told why the driver would be used.
37. Once settled back in healthcare, nursing staff began to follow the palliative care plan. An anxiety care plan was opened to monitor his psychological response to his diagnosis. Nurses were instructed to alleviate any feelings of anxiety, allow him the time to express his feelings and to ask any questions about his illness. Care plans were also opened for every symptom associated with his illness, and nursing staff were made aware of the level of care and support required to manage each area.
38. In the early hours of 8 August, the man became restless and experienced feelings of sickness. At 6.30am, a nurse found him in pain and feeling anxious. He was reassured but still appeared frightened and asked the nurse to stay with him for a while. He was seen by a district nurse in the afternoon and his syringe driver was replenished.
39. At 6.30pm, the doctor saw the man and had a long talk with him. The entry in his medical record stated that he appeared frightened and tearful and wanted a prisoner from his unit to visit him in healthcare. The doctor noted that the man asked if he was dying and was told, "You know the answer to that already". The doctor then asked him if he had any other concerns and he repeated his request to see another prisoner from his unit. The doctor explained to him that his request would be passed on to security and arranged for the chaplaincy to see him in the meantime.
40. By 8.00pm, the chaplain had arrived at his bedside and they said prayers together. Once again, the man said that he wanted another prisoner to visit "so he can hug him". The entry in his PCP stated that the healthcare manager would arrange the visit once his pain relief was under control.
41. His health continued to deteriorate and he was seen by the chaplain on a daily basis. Healthcare staff followed the adapted care plan closely and monitored his anxiety and pain relief levels. The man was also treated for

other symptoms attached to his illness and his diet and fluid intake was recorded. Nurses constantly rotated him in bed to prevent further pressure sores and noted that he did not like being moved, despite being told why it was necessary to change his position.

42. On 15 August, his condition worsened. The chaplain visited him twice, accompanied on the second occasion by the prisoner he wished to see. The chaplain contacted the man's next of kin and logged the event in a memo to the Director of Altcourse.
43. At 2.00am on 17 August, the night duty nurse entered his room to attend to his personal hygiene and change his bedding. At his request, the nurse stayed behind and sat at his bedside. At approximately 2.51am, the man passed away peacefully.
44. Immediately following his death, an incident log commenced and over the course of the next few hours most of the relevant parties were informed. The prison doctor on duty was informed at 3.00am and arrived at the prison at 4.33am. The doctor pronounced the man dead at 4.58am. The chaplain took responsibility for informing his next of kin that he had died. The duty director, started a debrief and the doctor, healthcare staff and prison staff who attended were thanked for ensuring the man's death was a dignified one. Staff were also informed that care and support services were in place if anyone felt they needed to access them.
45. The man's funeral took place on 24 August and the funeral costs were met by the prison.

ISSUES

46. The man participated well in the prison regime prior to his diagnosis and was beginning to settle into his long term sentence when he became ill. It is clear from his records that he preferred to remain on the unit to be treated, and this was honoured by the prison until such time that he could only be cared for properly in the healthcare centre.
47. I have no doubt that healthcare staff and unit staff did all they could, within their means, to manage the man's illness and make his life as comfortable and dignified as possible. He was continuously reassured when struggling to come to terms with his illness, received 24 hour inpatient care and, when rapidly deteriorating, was compassionately managed by senior prison staff, the chaplaincy and the healthcare team who followed his palliative care package closely.
48. That said, although there would have been no effect on the ultimate outcome for the man, the investigation highlighted a number of areas where practice could be improved.

Record keeping

49. Prison Service Order 1025 provides guidance on when and how to complete a Prisoner Escort Record (PER) form. Chapter 1 (1.8) states that 'A PER form is to be completed for every external movement of a prisoner, whether responsibility transfers to another agency or not and to whatever destination'. In this man's case, not all transfers to the outside hospital were accompanied by PER forms. Where a PER form was completed, it was not filled in accurately and had been separated from its back page which details the transfer, appropriate timings and whether restraints were used. Unfortunately, I have not been able to establish why these inaccuracies occurred.

The Director should remind both dispatching and escort staff of the purpose and importance of completing a PER form for every prisoner transfer and refer staff to PSO 1025 for further guidance.

Healthcare Records

50. Healthcare staff at Altcourse showed great determination and commitment in caring for the man during the last few weeks of his life. It is clear from his medical record that nurses overcame difficulties quickly to ensure he was made as comfortable as possible, and followed the palliative care plan meticulously. What is not always clear from the record is who his primary carers were for the duration of his stay in the healthcare unit and exactly when he was transferred to the outside hospital and returned. The man's medical records were often difficult to read, incorrectly initialled and signed, and below the expected standard.

The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council's guidelines for records and record

keeping, all medical records should be legible, up to date and in chronological order. In addition, audits of the quality and consistency of records should be undertaken in partnership with the PCT on a regular basis.

Release on Temporary Licence

51. The man had two stays in hospital, one of which resulted in him being away from the prison for approximately two and a half weeks. This second stay in hospital came at a time when he was undergoing exploratory procedures to confirm his diagnosis and was in some considerable pain. Whilst it is not clear whether release on temporary licence (ROTL) would have been appropriate, there is no evidence that senior prison staff considered the option as the best and most compassionate way to manage the man's stay in hospital.

The Director should remind senior staff to familiarise themselves with PSO 2300 and to consider ROTL as a compassionate option where prisoners experience lengthy stays in outside hospitals or other care environments.

Following a Death in Custody

52. Immediately following the man's death, both healthcare and prison staff began to implement the local contingency plan for a death in custody. A number of relevant individuals and agencies were contacted and made their way to the prison to carry out their responsibilities. However, it is clear from the log of events that, during the early hours of 17 August, the duty director, ran into difficulties when attempting to contact the police and duty coroner. Paragraph 3.1 of Prison Service Order 2710 (PSO 2710) *Follow up to Deaths in Custody* clearly lists all parties who require notification of a death in custody. The PSO also states that:

"Governors/Directors are responsible for developing, implementing and maintaining their local contingency plans and protocols for handling the aftermath of a death in custody and for ensuring lessons are learnt and shared".

The man's records show that it took the duty director approximately two and a half hours to contact the local police to inform them of his death and longer to contact the duty coroner. The log does not state when the duty coroner was finally informed. During the hot debrief, the duty doctor raised the issue of securing an improved emergency contingency plan in light of the difficulties. I commend the doctor for bringing this to the attention of the Director.

The Director should review the local emergency contingency plan and agree a joint protocol between the prison, the police and the coroner to outline actions required when a death in custody occurs. The protocol should focus particularly on ensuring that the contact details of all authorities required to respond to a death are updated regularly.

Good Practice

53. The chaplaincy team gave ongoing support to the man. They helped him when he experienced feelings of fear and frustration throughout his illness. Both the chaplain and senior prison staff should be commended, particularly for ensuring that his wish for a fellow prisoner to visit him in the healthcare centre was met before he died.

54. During the early hours of the morning of 17 August, the night duty nurse who attended to the man's personal needs also took the decision to remain at his bedside until he died. Her actions ensured that he died in the company of someone who had cared for him. The level of compassion and professionalism demonstrated deserves a particular mention.

CLINICAL REVIEW

55. The clinical review conducted by Liverpool Primary Care Trust commented that the man's illness, once formally diagnosed, was cared for holistically and appropriately by adapting the Liverpool Care of the Dying Pathway to the prison environment. The review also noted that this is recognised as a gold standard for terminal care and concluded that all that could be done was done for him.
56. The clinical reviewer also wrote favourably on the professional relationship between Aintree Hospitals NHS Trust and the prison healthcare team, particularly the communication between healthcare staff and outside hospitals.
57. The clinical review did comment adversely on the presentation and content of his medical records. A recommendation echoes my own finding in respect of the legibility of some records.

Good Practice

58. Communication between Aintree Hospitals NHS Trust and the prison healthcare staff was excellent and should be acknowledged.
59. The care given to the man was of a high standard and holistic, and the prison healthcare staff need to be acknowledged for this.

RECOMMENDATIONS

- 1. The Director should remind both dispatching and escort staff of the purpose and importance of completing a PER form for every prisoner transfer and refer staff to PSO 1025 for further guidance.**

The Office of Contracted Prisons accepted this recommendation and said the following:

“A Director’s Notice to Staff has been circulated reminding staff of the purpose and importance of completing a PER form.

- 2. The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council’s guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order. In addition, audits of the quality and consistency of records should be undertaken in partnership with the PCT on a regular basis.**

The Office of Contracted Prisons accepted this recommendation and said the following:

“Since the death of this man, a clinical review IT system has been installed. This should see the issue resolved. We believe that the clinical records were in chronological order.

- 3. The Director should remind senior staff to familiarise themselves with PSO 2300 and to consider ROTL as a compassionate option where prisoners experience lengthy stays in outside hospitals or other care environments.**

The Office of Contracted Prisons accepted this recommendation and said the following:

“Senior staff are familiar with PSO 2300 and in this case release on licence was considered”.

- 4. The Director should review the local emergency contingency plan and agree a joint protocol between the prison, the police and the coroner to outline actions required when a death in custody occurs. The protocol should focus particularly on ensuring that the contact details of all authorities required to respond to a death are updated regularly.**

The Office of Contracted Prisons accepted this recommendation and said the following:

“Local contingency plans have been reviewed and amended. Regular reviews are now diaried”.

GOOD PRACTICE

- 6. The chaplaincy team gave ongoing support to the man. They helped when he experienced feelings of fear and frustration throughout his illness. Both the chaplain and senior prison staff should be commended, particularly for ensuring that his wish for a fellow prisoner to visit him in the healthcare centre was met before he died.**
- 7. During the early hours of the morning of 17 August, the night duty nurse who attended to the man's personal needs also took the decision to remain at his bedside until he died. Her actions ensured that he died in the company of someone who had cared for him. The level of compassion and professionalism demonstrated deserves a particular mention.**
- 8. Communication between Aintree Hospitals NHS Trust and the prison healthcare staff was excellent and should be acknowledged.**
- 9. The care given to the man was of a high standard and holistic, and the prison healthcare staff need to be acknowledged for this.**

