The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR R
AGED 61
AT CAUSEWAY HOSPITAL
ON 20th OCTOBER 2017

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The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation of deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The objectives of death in custody investigations are set out in the Ombudsman's terms of reference and are to:

- establish the circumstances and events surrounding the death, including the care provided by the Prison Service;
- examine any relevant health care issues and assess the clinical care provided by the Trust;
- examine whether any changes in Prison Service or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Within the above objectives, the Ombudsman will identify specific matters to be investigated in line with the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

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Glossary

AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
AED	Automated External Defibrillator
ATR	Accompanied Temporary Release
CCTV	Closed Circuit Television
CJINI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
ECR	Electronic Care Record
ECR	Emergency Control Room
EMIS	Egton Medical Information System
GP	General Practitioner
IMB	Independent Monitoring Board
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PSNI	Police Service of Northern Ireland
PREPS	Progressive Regimes & Earned Privileges Scheme
PRISM	Prisoner Record and Inmate System Management
PTSD	Post-Traumatic Stress Disorder
SPAR	Supporting Prisoners At Risk (procedure)
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure
S/O	Senior Officer

Foreword from the Ombudsman

The death of a loved one is always difficult. The fact that a death occurs in custody, or shortly after someone is released from prison, has particular difficulties given the loss families experience when a loved one is taken into custody and the trust they must place in the Northern Ireland Prison Service (the Prison Service), the South Eastern Health and Social Care Trust (the Trust), and others, to ensure the safety and wellbeing of their loved one.

All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation.

This report will address and inform several interested parties, all of whom should learn from the findings. Where appropriate, recommendations will be made directly to the Prison Service and the Trust. Both organisations will then provide my office with a response indicating whether they accept my recommendations and what steps they are going to take or have taken to address them.

While these interested parties are important to ensure change to care in custody, this report is written with Mr R's family primarily in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am grateful to them for their contribution to this investigation and I appreciate their patience. I offer my sincere condolences to them on their sad loss and hope this report provides information to address some of the questions they raised and explains events leading up to Mr R's death. The learning, expressed in recommendations, will, I hope, bring some comfort to families who are grieving and confidence to those who have family members in custody.

I am grateful to the Prison Service, the Trust and the clinical reviewer for their contributions to this investigation. Others have helped in the information gathering process and to them I also extend my gratitude.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
7th November 2019

Section 1: Framework for this investigation

1.1 Background to Mr R's death

Mr R was diagnosed with a terminal cancer on 25th May 2016 while he was serving a sentence in Magilligan prison. He received treatment for his illness while in custody. However, his condition deteriorated rapidly on 15th October 2017 and he was transferred to the Causeway Hospital. He was released from custody on compassionate grounds on 18th October 2017 and sadly died on 20th October. As Mr R passed away within fourteen days of his release from prison, I have the discretion to investigate the circumstances surrounding his death and assess the care that he received while he was in custody.

This investigation was conducted in line with my terms of reference and provides explanations, where possible, to Mr R's family.

The specific issues explored in this investigation were:

- Whether Mr R's needs were adequately met by the Prison Service?
- If Mr R's health care needs were adequately managed when he was in prison?
- Was Mr R's transfer to the Causeway Hospital made at the appropriate time?
- Was Mr R's release on compassionate grounds made at the appropriate time?

1.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives (see Section 2). The following information was gathered and analysed by the Investigating Officer:

- Prison Service records including closed circuit television (CCTV) footage and telephone calls made by Mr R prior to his transfer to hospital; and
- Prison health care records and medical records from the Causeway Hospital.

All of this information was carefully examined and I have detailed the relevant matters, which underpin my findings, in this report.

1.3 Independent advice

I also obtained an independent review of the health care provided to Mr R from Dr Andrew Davies MBBS, MSc, MD, FRCP, a consultant in Palliative Medicine. Dr Davies

is currently a Specialty Lead for Supportive and Palliative Care/Consultant in Palliative Medicine at Royal Surrey County Hospital (St. Luke's Cancer Centre). He is also President of the Association for Palliative Medicine of Great Britain and Ireland.

The clinical reviewer provided me with a report setting out his opinion on the matters I asked him to consider. I have included Dr Davies' opinion on relevant health care matters in my investigation report.

Section 2: Questions raised by Mr R's family

The previous Prisoner Ombudsman received a letter on 30th November 2017 from Mr R's family highlighting a number of concerns about his care. These are summarised below:

- Matters relating to health care

  The family did not believe that Mr R's needs associated with his terminal illness were appropriately managed while he was in prison. They gave examples of a number of aspects of his care which they were not satisfied with including: the response to repeated falls, the absence of walking aids, the condition of his legs, his medication regime and they questioned why his frail condition on 14th October had not prompted an immediate transfer to hospital. The family stated they were also unaware of the circumstances leading to Mr R being brought to hospital on 15th October 2017.

- Timeliness of the compassionate release

  The family felt that Mr R should have been released on compassionate grounds sooner. They highlighted that Mr R was unconscious and unable to sign the compassionate release paperwork when it was issued. They were very concerned about his quality of life in the weeks before he died.

- Lack of family involvement in care planning

  The family were grateful that they were permitted to attend hospital appointments with Mr R but expressed frustration that they could not speak to prison health care staff directly about his care and felt they were not given sufficient input into his care planning while he was in prison. They highlighted some positive interactions with prison staff they spoke to during hospital visits and Mr R's personal development officer who they said had a good relationship with him.

- Transport to hospital appointments

  The family highlighted that on a number of occasions Mr R had been brought to hospital in a prison van which was not appropriate considering his medical condition.

- Family visits

  The family found the lack of privacy during family visits distressing, particularly in the latter stages of his illness.

Responses to these issues will be addressed in the following sections of this report.

Section 3: Summary of the circumstances and events surrounding Mr R's death

3.1 Chronology

Mr R was committed to Maghaberry prison on 11th April 2014 and he was transferred to Magilligan Prison on 23rd July 2014.

Shortly after he arrived in Magilligan prison, Mr R requested to be accommodated on House Block 2 (H2) A&B landing[1] and he moved there on 15th September 2014. He remained on this landing until he was transferred to hospital on 15th October 2017.

When he first came into prison Mr R was recorded as having a history of diabetes, mobility issues, heart problems and that he smoked. Urgent referrals were made to and actioned by physiotherapy and occupational therapy.

Mr R's medical ailments were regularly monitored throughout the time he was in prison and he engaged with a range of health care services.

As part of the regular monitoring of his diabetes blood tests were done on 11th April 2016. Prison health care were notified of the results and Mr R was immediately referred to an outside hospital as he was suspected of being anaemic and required a blood transfusion. However investigations conducted by the hospital showed an abnormal mass which was suspected of being a primary lung cancer with secondary liver cancer.

On 25th May 2016 Mr R was advised that he had an incurable, aggressive lung cancer and was told that his prognosis was difficult to predict: it could be up to 2-3 months without treatment or up to 11-12 months with treatment.

Following this diagnosis a range of measures were put in place by the Prison Service and Trust to care for Mr R, including: palliative care and mental health support, pain relief management and adjustments to his diet, visits, transport and additional help from his peers.

On the 7th September 2016 Mr R requested to be released from custody on compassionate grounds. On 13th September 2016 a Governor advised him that he did not meet the criteria but that his health would be monitored and, when

[1] This landing predominantly accommodates older prisoners, as well as those who may be vulnerable due to the nature of their offences and/or who have complex care needs. The regime is tailored to meet the needs of the men who live there.

appropriate, a decision would be made and steps taken to release him on compassionate grounds.

In the intervening period Mr R attended numerous appointments and he was regularly reviewed and monitored by medical staff responsible for his care both in prison and in the community.

Mr R was discharged from Oncology on 9th October 2017 due to a significant deterioration in his condition. He continued to receive general palliative care from prison health care and specialist nursing care from a community palliative care team.

Mr R's condition continued to deteriorate and on 15th October 2017 he was transferred to the Causeway Hospital's Accident and Emergency department.

He was released from custody on 18th October 2017 on compassionate grounds, under Article 20 of the Criminal Justice (Northern Ireland) Order 2008. He passed away two days later on 20th October 2017 at the Causeway Hospital.

A post mortem was not conducted. The death certificate recorded the cause of death as Metastatic Lung Cancer.

Section 4: Relevant issues and assessment of the care provided by the Prison Service

Given the nature of Mr R's condition it is difficult to consider the care provided by the Prison Service in isolation from the Trust. While this section aims to focus on the relevant issues for the Prison Service inevitably there is some overlap with clinical care.

4.1 Adjustments made by the Prison Service to address Mr R's needs

Following Mr R's diagnosis eight case conferences and one 'mini' case conference took place between 29th June 2016 and 21 September 2017 to discuss his medical and care needs. These were attended by staff from the Prison Service and the Trust. A representative of the Independent Monitoring Board (IMB) attended one meeting and Mr R also took part in several discussions.

At the initial case conference it was evident that Mr R did not want any of his medical information to be shared with Prison Service staff and he left the meeting. However, after a discussion with his Sentence Manager on 8th July 2016 he changed his mind and was content that information was shared with those responsible for caring for him. This facilitated Prison Service and Trust staff to work collaboratively to provide care for Mr R from this point.

The case conference records showed that a range of support and reasonable adjustments were to be put in place to address Mr R's care needs.

These included:

- advice on relaxation and breathing techniques from gym staff;
- agreement for Mr R's Sentence and Case Managers to meet with him weekly;
- agreement for the kitchen to supply Mr R with any foods he required and additional items from the prison shop;
- provision of an additional heater for his room;
- approval for family visits to take place in a legal room and assistance with getting to and from visits;
- the provision of hand sanitiser for anyone who would be in contact with Mr R;
- approval for hospital escorts to be completed in a car or mini bus rather than a cellular van;
- approval to attend hospital appointments without being handcuffed;
- approval for family to attend hospital appointments;

- the provision of a new mattress;
- approval of Accompanied Temporary Release (ATR) on 15th December 2016 and, 1st March 2017.
- provision of carers to help with daily activities, the cleaning of his room and assist with evacuation if necessary;
- provision of hand rails; and
- agreement for Mr R to be accommodated in the Advanced Care Room at the appropriate time.

Mr R's care was discussed at two Senior Management Meetings on 8th September 2017 and 13th October 2017. At one meeting concerns were raised by prison officers about arrangements for Mr R getting in and out of bed. The Trust's Operational Nurse Manager (Nurse A) advised prison staff that a health care plan was in place and if he fell, Mr R should be made comfortable and that sliding sheets had to be used to allow him to be moved safely.

I am satisfied (notwithstanding the issues addressed separately below) that Mr R received good care from the Prison Service and, in conjunction with the Trust, a number of reasonable adjustments were made. At two meetings Mr R himself acknowledged that the care provided by staff in H2 was good. This was further endorsed by the IMB representative.

4.2 Family involvement in care planning

Mr R's family acknowledged they were permitted to attend outside hospital appointments and attended periods of accompanied temporary release. On one occasion though, the family were not informed by the prison that a hospital appointment could not be kept and it wasn't until Mr R contacted another relative that they realised it was not going ahead.

The record of the case conference on 16th August 2017 included a proposal to meet with the family every 3 months and at a further case conference the following month it was suggested that consideration be given to inviting the family to the next case conference. The Deputy Governor decided not to action this at that time.

If these proposals had been actioned the family may have felt more involved and better informed as to how Mr R's needs were being addressed during the course of his illness. Mr R's family said that it would be beneficial to begin this conversation earlier with those who have received a terminal diagnosis and their families. They felt strongly that effective and ongoing communication with families, during the course

of an illness, could enhance the care provided to the person in custody and the experience of their families when in this situation.

I appreciate that such decisions need to be taken on a case by case basis and the needs and wishes of individual prisoners and their families will vary. I recommend that the Prison Service establish a way of ensuring that there is effective and ongoing communication with the families of prisoners diagnosed with a terminal illness in custody. Work is already underway to develop a Family Liaison role across the Service and this might take account of the needs of families who find themselves in similar circumstances to those of Mr R's family.

4.3 Transport to hospital appointments

Although approval had been given for Mr R to be brought to and from hospital appointments in a car rather than a cellular van, on two occasions this arrangement broke down. Mr R raised complaints with the Prison Service which were referred to the Prisoner Ombudsman after the internal complaints process had been exhausted. The Prison Service accepted mistakes were made regarding the form of transport to be used and apologised. The Prison Service gave a further assurance that appropriate markers had been placed on Mr R's record to ensure this could not happen again. There do not appear to have been any further issues regarding transport to hospital appointments.

4.4 Location of family visits

The Prison Service gave approval for visits to take place in a legal room from 18th August 2016 due to the nature of Mr R's illness. The record of the Case Conference on 20th October 2016 indicated that visits were taking place in this location. However, as Mr R's family reported and from inmate visit records, visits, including his last visit with family members on 14th October 2017, took place in the main visits room. As mentioned earlier the CCTV footage showed that Mr R required considerable assistance to access visits on 14th October 2017.

I appreciate the family's concern about the lack of privacy in these circumstances as well as the physical toll getting to and from the main visits room had on Mr R, especially in the latter stages of his illness. It would have been more appropriate for Mr R's family to have an undisturbed visit so close to his death. It is not clear why visits were taking place in the main visits hall when approval had be given for them to take place in a legal room or what alternative locations might have been considered.

4.5 Timeliness of compassionate release

On 7th September 2016 Mr R requested that he be considered for release from custody on compassionate grounds[2]. He was told that he did not meet the criteria for release at that time but that his condition would be monitored and appropriate steps taken when necessary.

In the notes of a Case Conference held on 16th August 2017 there is reference that compassionate release had been considered in the preceding three months but Mr R again did not meet the criteria. While Prison Service Headquarters is unable to provide records it is evident that ongoing consideration was given to his release to determine when this would be appropriate.

On 18th October 2017, the Prison Service sought approval for compassionate release. It noted doctor's advice that Mr R had met the criteria for release.

Unfortunately the deterioration in Mr R's health was very rapid. This can be gauged from the record of the Senior Management meeting on 13th October 2017, just seven days before Mr R died, when it was reported Mr R was still able to walk and continued to be cared for within the prison. Mr R had a visit with family members on 14th October 2017. CCTV footage of this visit was viewed and he is seen walking into the visits room albeit with considerable assistance.

It appears that Mr R was released on compassionate grounds once he met the criteria. There is nothing to indicate that this decision could have been made sooner and there is some evidence that the decision was kept under review.

The clinical reviewer considers this question from a clinical perspective in the following section.

Section 5: Relevant health care issues and assessment of the clinical care provided by the Trust

5.1 Background

[2] The provisions of the Scheme under which Mr R's release was considered are set out in the Northern Ireland Prison Service Release on Compassionate Grounds under Article 7 Life Sentences (NI) Order 2001 & Article 20 Criminal Justice Order (NI) 2008 policy. One of the following two criteria must be met for a release on compassionate grounds to be considered: that the prisoner is suffering from a terminal illness and death is likely to occur soon; or that the prisoner is permanently incapacitated and that he or she requires a level of care that cannot be provided in a prison environment.

Since 2008 prison health care services at Magilligan prison have been provided by the South Eastern Health and Social Care Trust (the Trust). There is a 24 hour primary health care service and the mental health team is on site Monday to Friday between 08:00-17:00. There are no in-patient beds in the prison.

In their most recent inspection of Magilligan prison, Criminal Justice Inspection Northern Ireland (CJINI) found that health services had improved and mental health provision was particularly good for those known to the service.

5.2 Events prior to Mr R's diagnosis

When Mr R was first committed to custody his health care needs were assessed. Urgent referrals were made to physiotherapy and occupational therapy to determine if any reasonable adjustments were required due to a leg injury Mr R had sustained in 1985. He was subsequently assessed by both services, some adjustments and advice were offered and he was discharged.

He attended a diabetes review on 13th June 2014 and was noted to have good diabetic control. From then until April 2016 he engaged in a number of health care services including: podiatry, retinopathy screening, optometry occupational therapy, dental services and smoking cessation. There was one issue with medication management in April 2015 and this was successfully resolved after Mr R made a complaint.

On 8th April 2016 a prison doctor (Doctor A) requested that bloods be taken and tested as part of a diabetes review. The bloods were taken on 11th April 2016. On the same day the Trust received a telephone call from the laboratory in relation to the blood results and an appointment was made for Mr R to see a doctor in the prison the following day.

5.3 Diagnosis of Mr R's terminal illness

On 12th April 2016 Mr R attended the appointment with a doctor (Doctor A) who explained the blood test results and that he was to be referred to the Causeway Hospital's Accident and Emergency Department as it was suspected he was anaemic and needed a blood transfusion. Investigations carried out by the hospital showed there was an abnormal mass on his lung which was suspected to be lung cancer with secondary cancers in his liver. Mr R remained in hospital for further investigations and a blood transfusion. He was discharged on 18th April 2016 and returned to Magilligan prison.

Mr R attended day procedures at outside hospital on 21st April 2016, 4th May 2016 and 7th May 2016. His case was discussed at multi-disciplinary meetings at Antrim Hospital on 9th May 2016 and 23rd May 2016. A referral was made and accepted by Oncology on 23rd May 2016.

On 25th May 2016 Mr R attended the Respiratory Outpatient Clinic and was advised by a Lung Cancer Clinical Nurse Specialist that further investigations revealed that he had an aggressive type of incurable lung cancer. He was offered chemotherapy treatment and advised that his prognosis was difficult to predict. It was predicted that, without treatment, Mr R could survive up to 2-3 months or 11-12 months with treatment.

On 27th May 2016 Mr R attended a review with a Nurse (Nurse B) and a Governor (Governor A). Mr R was happy for the Governor to attend as he wanted to address an issue about the officers who had been present at the Respiratory Outpatient Clinic on 25th May 2016 and also to discuss his medical issues. The Governor addressed Mr R's issues and gave an assurance that they would not be repeated. It was noted that Mr R was content to remain in his current residential location and that he would engage appropriately to ensure he got the appropriate care for his medical condition.

5.4 Post diagnosis care

Mr R saw a prison doctor (Doctor A) on 1st June 2016 to discuss whether he wanted his family to accompany him to an appointment scheduled for 6th June as he may be offered chemotherapy. Mr R was advised to consider moving to Maghaberry prison during chemotherapy cycles to reduce travelling distance, but he chose to remain at Magilligan.

Mr R attended 4 cycles of palliative chemotherapy on 6th June 2016, 27th June 2016, 18th July 2016 and 8th August 2016. He was frequently reviewed and monitored by the Trust throughout his chemotherapy cycles.

He attended Oncology Clinics to monitor his response to treatment and his ongoing symptoms between13th September 2016 to 9th October 2017.

Mr R was seen by a Hospice Community Nurse on 4th November 2016 to increase pain relief for back pain; 16th November 2016 to increase his pain relief further; 2nd June 2017; 21st August 2017 as he was feeling further occasional pain in his back and to discuss evident changes in his condition: and she continued to see Mr R on a weekly basis.

Mr R was admitted to hospital on 22nd August 2017 for assessment, as he had been experiencing extreme tiredness and some abdominal bloating. He remained in hospital until 25th August 2017 and was discharged with noted disease progression. A radiology report dated 4 September 2017 noted significant interval deterioration with progression of pulmonary and liver metastasis.

On 26th September 2017 Mr R moved into the Advanced Care Room[3] in H2 where his medical needs could be better managed.

He was discharged from Oncology follow-up on the 9th October 2017 as he was assessed as no longer being fit enough for further chemotherapy or radiotherapy treatment. Palliative care continued to be provided by the community palliative care team.

On 15th October 2017 Mr R was referred to the Causeway's Hospital Accident and Emergency department as he had progressively deteriorated. He remained in hospital and died there on 20th October 2017.

5.5 Independent review of health care

Dr Davies was commissioned to carry out a clinical review of the care provided to Mr R. He was asked to address specific matters raised by my Investigating Officer and to provide comments on clinical aspects of the questions posed by Mr R's family.

Dr Davies' opinion on these matters is set out below.

(1) The provision of primary and secondary health care and treatment including palliative care and medication management

In Dr Davies' opinion Mr R appeared to have received good primary health care, good generalist palliative care (i.e. from staff in the prison) and good specialist palliative care (i.e. from the Northern Ireland Hospice North Coast Community Team). Moreover, medication was made available to manage pain and other symptoms, including various controlled substances.

He said Mr R appeared to have received good oncology care and he found no shortcomings in care or service provision.

[3] The Advanced Care Room is a larger room off the main residential landing. It can accommodate two patients and the additional space allows for hospital beds and other equipment to be available to the prisoner. The location of the room facilitates closer monitoring by prison and health care staff.

(2) The adequacy of decision making and the timeliness of the referral to transfer Mr R to Hospital on 15th October 2017

Dr Davies established that the stated reason for referral to hospital was "dehydration/further management", but blood tests on admission excluded dehydration. He said the hospital's medical team deemed that the deterioration was due to "progression of metastatic lung ca (*cancer*)", and not due to any reversible medical condition.

In light of the blood tests conducted on admission to hospital, Dr Davies said that there was no specific indication for hospital admission at that time which made the question about timeliness of referral redundant. It was his view that the patient could have remained within the prison (for end-of-life care) with the ongoing support of the community palliative care team.

(3) Whether there was an earlier opportunity to transfer Mr R to a hospital or hospice prior to 15th October 2017

Dr Davies concluded that Mr R would not have benefitted from an earlier transfer to the hospital (see above). He commented that Mr R may have benefitted from a transfer to the hospice. However, he pointed out that the decision to admit a patient to a hospice is based on a range of factors and provision is limited, with only 5.7% deaths occurring in hospices in England during 2016. Dr Davies was unable to find data for Northern Ireland, but in his opinion Northern Ireland was unlikely to be very different from England.

(4) The impact of the missed red flag appointment on 17th January 2017 and incident reports relating to medication issues

Dr Davies said that the missed CT scan appointment on 17th January 2017 – due to transport not being arranged - had no impact on Mr R as the appointment had been rescheduled and the scan itself was normal.

In terms of the incidents relating to "falls" (16th September 2017 and 15th October 2017), Dr Davies' opinion was that as Mr R sustained no injuries, these incidents had no impact on him.
Dr Davies was also satisfied that there was no adverse impact on Mr R of the medication issues which arose on 22nd January 2017, 4th February 2017 and 19th June 2017.

While all of the above matters raised questions in the minds of Mr R's family, the clinical reviewer assessed that they had no adverse impact on him.

(5) The specific concerns raised by Mr R's family

Dr Davies' opinion was that Mr R appeared to have received good care and that the timing of the decisions to transfer him to hospital and approve his release on compassionate grounds was appropriate.

Dr Davies also reviewed the specific questions around Mr R's health care raised by his family on Page 8 and was satisfied that:

- Mr R had a specific nursing care plan relating to mobility and risk of falls and his cell was adapted to limit the risk of falls;
- The problems with Mr R's legs were regularly assessed and had been correctly managed;
- Mr R was switched from oral diabetes medication to subcutaneous insulin whilst in hospital, and there was no suggestion that his intermittent confusion was related to low blood sugar levels; and
- The hospital records indicated that Mr R was treated with sedative drugs to manage his terminal agitation on 18th October 2017 and so was not mentally competent at this time.

(6) Any other observations relevant to Mr R's care

Mr R was referred/discharged a number of times by the community palliative care team. In view of the nature of his disease, Dr Davies said he would have expected them to have kept him under regular review (initially infrequent review) rather than discharge him a number of times.

(7) Any learning opportunities and recommendations for future practice

In keeping with other independent reviews of health care, reviewers are asked to comment on any learning opportunities and recommendations for future practice.

In this case Dr Davies noted that Mr R did not appear to have an advance care plan, and specifically a preferred place of death. While he acknowledged that writing a plan in this situation was difficult, it would have been useful to have explicitly explored the options for end-of-life care.

(8) Overall opinion

Dr Davies' opinion was that Mr R received good care from the Trust, the Prison Service, the oncology centre/local hospital and from the community palliative care team.

In Dr Davies' view, Mr R probably received better care than many community-living patients with advanced cancer in Northern Ireland (and the rest of the United Kingdom).

Section 6: Changes in Prison Service or Trust operational methods, policy, practice or management arrangements which could help prevent a similar death in future

6.1 Overall finding

Having taken account of the findings of this investigation and the clinical review, I did not find that there was any learning which might have prevented Mr R's death or would reduce the risk of a similar death in future.

Mr R died from natural causes and the diagnosis of his illness was detected due to his diabetes being regularly monitored. The response to the finding of an abnormal blood test result was quickly addressed and sadly Mr R was diagnosed with an incurable lung cancer a short time later.

This investigation identified three learning points which may further assist the Prison Service and the Trust to manage someone with a terminal illness.

6.2 Learning for the Northern Ireland Prison Service

Although written details of the final decision making surrounding Mr R's release on compassionate grounds was available to this investigation, the consideration given to earlier applications was not fully documented. In the interests of transparency appropriate records should be maintained of all correspondence between a prison and Prison Service Headquarters surrounding decisions about compassionate release.

Recommendation 1
Compassionate release decisions: The Prison Service should ensure that all communication in respect of compassionate release decisions is fully documented.

Mr R's last visit with his family took place in the main visits hall even though approval had been given for visits to take place in a location which provided more privacy. It is important that consideration is given, ideally in consultation with a prisoner and his family, to what alternative arrangements can be made for family visits towards the end of someone's life and where an alternative is agreed, this is adhered to.

Recommendation 2
Visits: The Prison Service should consider alternative locations for family visits for prisoners approaching the end of their life and, when these are agreed, that they are adhered to.

Supporting a relative with a terminal illness at any point is very challenging but when that person is in prison, it can exacerbate feelings of helplessness. The experience of Mr R's family suggests that more could be done to communicate effectively with families during the course of an illness. The Prison Service are working to establish the role of Family Liaison across the Service and this work could take the issues identified in this case into account.

Recommendation 3
Communication: The Prison Service should extend the Family Liaison role currently under development to ensure there is effective and ongoing communication with the families of prisoners diagnosed with a terminal illness in custody.

The Prison Service accepted these recommendations and plans to consider these at the Service's Safer Custody Steering Committee to agree the appropriate method of implementation across all establishments. It has also committed to extending the remit of the Family Liaison role.

6.3 Learning for the South Eastern Health and Social Care Trust

The clinical reviewer noted that Mr R did not appear to have an advance care plan and while he acknowledged this may be difficult in a prison environment he felt it would have been useful to have explicitly explored the options for end-of-life care.

Recommendation 4
Advance care plan: The clinical Director for Prison Health care should ensure an advance care plan is in place for terminally ill patients.

The Trust noted that the clinical reviewer found that Mr R had received good care. It acknowledged that it did not have a formal advance care planning process in place and welcomed this recommendation in order to consider how it could further develop its services.

Section 7: Conclusions

With regard to my responsibilities to investigate Mr R's death and specifically considering the objectives of my investigation, I draw the following conclusions:

1. My investigation established the circumstances and events leading up to Mr R's death on 20th October 2017. I am satisfied that, overall, the Prison Service provided appropriate care and made reasonable adjustments to address Mr R's needs in prison.

2. I am satisfied that there was nothing to indicate that the Prison Service decision to release Mr R on compassionate grounds could have been made sooner.

3. In respect of health care issues I endorse the opinion of the clinical reviewer that Mr R received good clinical care from the Trust and other providers.

4. In light of the advice provided by the clinical reviewer, I am satisfied that there were no clinical grounds to transfer Mr R to hospital earlier than the 15th October 2017.

5. I am content that the investigation into Mr R's death has not highlighted any need for changes to be made in Prison Service or Trust operational methods, policy, practice or management arrangements which could help prevent a similar death in future.

6. I identified four lessons which may assist the Prison Service and the Trust in managing other terminally ill prisoners:

a) The Prison Service should ensure that all communication in respect of compassionate release decisions is fully documented.
b) The Prison Service should consider alternative locations for family visits for prisoners approaching the end of their life and, when these are agreed, that they are adhered to.
c) The Prison Service should extend the Family Liaison role currently under development to ensure there is effective and ongoing communication with the families of prisoners diagnosed with a terminal illness in custody.
d) The clinical Director for Prison Health care should ensure an advance care plan is in place for terminally ill patients.

7. Mr R's family raised a number of concerns relating to his care, these were taken into account during my investigation and addressed, where possible, in this report.

- Matters relating to health care – my investigation established that Mr R received good care.
- Timeliness of compassionate release – I am satisfied that Mr R was released on compassionate grounds when he met the criteria.
- Lack of family involvement in care planning and family visits – I am satisfied that Mr R's family were able to accompany him to hospital appointments and were present during periods of accompanied release from prison. I noted that consideration was given to involving his family in discussions about his care although this had not been actioned before his death. I acknowledged that Mr R's family might have been afforded greater privacy during his last visits with them and that the Prison Service should take steps to enhance communication with families.
- Transport to hospital appointments – It is evident that mistakes were made and that the Prison Service acknowledged and addressed this.

8. I hope that Mr R's family will find some comfort in the findings of this report that their father received good care from the Prison Service and the Trust and that a number of learning points have been identified to help others who find themselves in a similar situation.

9. In order to assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, I will provide the Coroner with the materials underlying my investigation.