Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shafaq Khan, a prisoner at HMP/YOI Hindley, on 28 February 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Shafaq Khan died in hospital of sepsis, pneumonia, pulmonary thromboembolism and peripheral gangrene (following a cardiac arrest) on 28 February 2023, while a prisoner at HMP Hindley. He was 52 years old. I offer my condolences to Mr Khan's family and friends.

The clinical reviewer concluded that the care Mr Khan received at HMP Hindley was not equivalent to what he could have expected to receive in the community. Mr Khan was on a self-management plan for his diabetes, and the clinical reviewer considered that this was not appropriate and healthcare staff should have provided more oversight.

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

Adrian Usher
Prisons and Probation Ombudsman **June 2024**

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Summary

1. On 19 February 2021, Mr Shafaq Khan was convicted and sentenced to eight years in prison for manslaughter. He was sent to HMP Forest Bank. On 26 April 2022, Mr Khan was moved to HMP Hindley.

2. Mr Khan had a significant medical history, which included high blood pressure and type two diabetes. Mr Khan was on a self-management plan for his diabetes, and he was aware of his responsibilities with his diet.

3. On 13 June, a GP at the prison noted that Mr Khan's blood glucose level had increased which indicated he was likely to develop diabetic complications. The GP referred Mr Khan to Endocrinology at the hospital.

4. At 11:14am on 19 December 2022, an officer found Mr Khan unresponsive in his cell. The officer called a medical emergency code and healthcare staff attended. Control room staff called an ambulance immediately. Mr Khan went into cardiac arrest and healthcare staff started cardiopulmonary resuscitation (CPR) until the paramedics arrived. When the paramedics arrived, Mr Khan was breathing but he was unconscious.

5. At 12:38pm, the paramedics took Mr Khan to hospital. Two officers escorted Mr Khan and he was not restrained.

6. Mr Khan had abnormal blood results with a very high glucose reading and he was placed in an induced coma.

7. Later that day, the hospital informed healthcare staff at Hindley that Mr Khan had diabetic ketoacidosis (DKA - when there is a severe lack of insulin in the body, so the body is not able to break down sugars for energy) and an acute kidney injury (AKI - when the kidneys suddenly stop working properly) due to dehydration.

8. Mr Khan remained unwell in hospital. On 28 February 2023, it was confirmed that Mr Khan had died.

Findings

9. The clinical reviewer concluded that the care Mr Khan received at HMP Hindley was not of the required standard and therefore not equivalent to what he could have expected to receive in the community. She was concerned about the lack of oversight of Mr Khan's high blood pressure and diabetes management and communication between the GP services at the prison and healthcare staff.

10. Recommendations

11. The Head of Healthcare should ensure that there is prompt and effective communication between the GP services and the healthcare team to ensure alerts and triggers for prisoners are monitored appropriately.

12. The Head of Healthcare should ensure that healthcare staff complete a full set of clinical observations, including a NEWS2 score, when a prisoner requires a healthcare assessment, to ensure that patients who are deteriorating, or at risk of

deteriorating will have a timely initial assessment by a competent clinical decision maker.

The Investigation Process

13. HMPPS notified us of Mr Khan's death on 28 February 2023.

14. The investigator issued notices to staff and prisoners at HMP Hindley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Khan's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Khan's clinical care at the prison. The investigator and clinical reviewer conducted two joint interviews on 6 April 2023.

17. We informed HM Coroner for Bolton of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Khan's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Khan's daughter asked about Mr Khan's clinical care at Hindley, which has been addressed in the clinical review report. Mr Khan's daughter also asked about the outcome of the prison's internal investigation into the actions of a member staff. We have addressed this issue in this report and in separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

20. Mr Khan's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP/YOI Hindley

21. HMP/YOI Hindley is a category C prison and holds approximately 540 convicted adult males and young offenders. Spectrum Healthcare provide primary healthcare services and nurses are on duty between 7.00am and 9.00pm every day. Greater Manchester Mental Health Trust provides mental health services, and staff are also on duty between 7.00am and 9.00pm every day.

HM Inspectorate of Prisons

22. The most recent inspection of Hindley was in December 2017. Inspectors reported work was ongoing to develop nurse-led care planning for patients with long term conditions. At the time of the inspection there were low numbers of patients on chronic disease registers who were overseen by nurses and the GP.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 2022, the IMB reported that the splitting of the healthcare contract provider in that year provided a less integrated service and less cross-departmental support than the previous year. However, the service provided was valued by prisoners and they expressed a high level of satisfaction with it.

Previous deaths at HMP Hindley

24. Mr Khan was the second prisoner to die at Hindley since February 2020. The previous death was self-inflicted. There are no similarities between our findings in the investigation into Mr Khan's death and the investigation findings for the other death.

Key Events

25. On 19 February 2021, Mr Khan was convicted and sentenced to eight years in prison for manslaughter. He was sent to HMP Forest Bank. On 26 April 2022, Mr Khan was moved to HMP Hindley.

26. Mr Khan had a significant medical history that included ischaemic heart disease, type two diabetes and he had a coronary artery bypass grafting in 2020. He was on a self-management plan for his diabetes. This involved Mr Khan being seen in the diabetic clinic for health promotion advice, diet and exercise advise and a review of his blood sugar readings. Mr Khan was aware of his responsibilities regarding his diet and that he had to contact healthcare if his blood sugar levels were greater than 10mmol/L (risk of hyperglycaemia with high blood sugar readings). The Head of Healthcare told us that healthcare staff implemented this plan for Mr Khan in accordance with NICE guidance NG28 which advises that there should be an individualised approach to care planning including the patient's preferences, education and monitoring.

27. When he arrived at Hindley, a nurse completed Mr Khan's first and secondary health screen and noted no concerns. The nurse referred Mr Khan to a GP for further review and an appointment was arranged for 16 May.

28. On 16 May, a GP at the prison saw Mr Khan as planned. He noted his medical conditions and that all his clinical observations were normal. The GP noted that he had no recent blood or urine test results for Mr Khan and that his last blood sugar reading, taken in January, was very high. The GP also recorded that Mr Khan's blood pressure was slightly raised when he arrived in reception on 26 April. The GP requested blood tests and urine samples to be taken. However, there is no evidence that a task was sent on SystmOne (prisoner electronic medical record) for a nurse to action. Healthcare staff did not take blood or urine samples until almost one month later, on 13 June.

29. On 13 June, a GP at the prison reviewed Mr Khan's blood test results and noted that his blood sugar reading had increased from 106mmol/mol in January to 140mmol/mol. This indicated Mr Khan had too much sugar in his blood and he was more likely to develop diabetic complications. The GP saw Mr Khan on 30 June. Mr Khan told him that he had been compliant with his medication but had increased his carbohydrate intake. The GP gave Mr Khan some dietary and weight loss advice, prescribed sitagliptin to help lower his blood sugar and manage his diabetes and referred him to Endocrinology at the hospital for further review. There is no evidence that healthcare staff followed up this referral as they should have done. A GP at the prison and secondary care services saw Mr Khan for various conditions related to his diabetes over the months that followed.

30. The GP services at the prison did not share the irregular blood sugar readings that were taken with nursing staff and therefore the nurses did not act accordingly. The Head of Healthcare told us that Mr Khan was referred to the long-term condition clinic for monitoring and oversight of both hypertension and diabetes, but the long-term condition clinic nurse was on maternity leave and therefore Mr Khan's care was being managed by the GP services at the prison. Mr Khan was last seen by the GP on 24 November.

31. On 16 December, an officer made an entry in the wing observation book and reported that Mr Khan had pressed his emergency cell bell and said that he had felt unwell for the past few days. He was unable to come out of his cell and said that he was worried about his health as he was struggling with his ribs and chest.

32. Later that evening, a nurse saw Mr Khan. She took his observations, and they were normal. She noted that Mr Khan did not have shortness of breath. She advised him that he might have the flu, so she would need to test him and that he needed to isolate until his results were back.

33. A prisoner who lived on the same wing as Mr Khan provided a written police statement. He said that on the 16 December, he saw Mr Khan coming up the stairs and he looked really ill. He asked Mr Khan if he was ok, and Mr Khan said no, and that he thought he was dying. Mr Khan said he felt terrible and had never felt like that in his life. He did not tell staff about what Mr Khan had said. He then said he saw Mr Khan again the next day (Saturday), and he was struggling to sit up.

34. On 17 December, healthcare staff took a swab from Mr Khan that came back positive for influenza (flu) however a full set of observations were not taken including a NEWS2 score (which monitors clinical deterioration), and a blood sugar reading was also not taken. Mr Khan was advised to drink plenty of fluids, but he continued to deteriorate.

35. On 18 December, a nurse saw Mr Khan because the wing staff reported he was struggling to breathe. She noted that Mr Khan had a normal pattern of breathing and was not in any obvious respiratory distress. Mr Khan told her that he was feeling achy all over, lethargic, nauseous at times and had diarrhoea. She told Mr Khan to take paracetamol regularly with plenty of fluids. She said that she would be back to check on him later that day and Mr Khan said he was happy with the plan. There is no evidence that healthcare staff returned to review Mr Khan that day.

Events of 19 December

36. In his statement, a prisoner said that Mr Khan's cellmate had told him that Mr Khan had been asleep since 10.00am the previous morning (Sunday). (The exact timing of events on 18 December is unclear but given that Mr Khan was seen by a nurse at some point that day, Mr Khan may well have been asleep for many hours.) The prisoner said he was concerned because this was not normal for Mr Khan.

37. At approximately 8.10am, the prisoner spoke to Officer A and told him that he needed to call healthcare, as Mr Khan had been asleep for 22 hours. He said that the officer sniggered and responded by saying Mr Khan was probably having a laugh. The officer did not contact healthcare or check on Mr Khan.

38. At 11.14am, an officer went to Mr Khan's cell to give him his lunch. Mr Khan was lying on his bed unresponsive. The officer radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and healthcare attended. Control room staff called an emergency ambulance.

39. Healthcare staff noted that Mr Khan was unresponsive and had the smell of ketones on his breath, indicating DKA. Healthcare staff moved Mr Khan onto the floor. Mr

Khan went into cardiac arrest and healthcare staff performed CPR until the paramedics arrived.

40. At 12.03pm, the first response paramedics arrived and examined Mr Khan and, at 12.04pm, the second rapid response ambulance arrived. Mr Khan was unconscious but breathing. At 12.38pm, Mr Khan was taken to hospital by emergency ambulance. Two officers escorted Mr Khan and he was not restrained.

41. An officer was appointed as the prison's family liaison officer. Arrangements were made to take Mr Khan's family to see him in hospital that day.

42. At 5.24pm, the hospital informed healthcare staff at Hindley that Mr Khan had been placed in an induced coma and that he had abnormal blood results with a very high glucose reading.

43. At 8.21pm, the hospital told healthcare staff at Hindley that Mr Khan had DKA and acute kidney injury due to dehydration.

44. Mr Khan remained unwell in hospital and developed sepsis and other complications. At 9.00am on 28 February 2023, it was confirmed that Mr Khan had died.

Events following Mr Khan's death

45. Following Mr Khan's death, Greater Manchester Police opened an investigation into the actions of Officer A. They were particularly concerned about him allegedly being dismissive of the prisoners concerns about Mr Khan's health. The police concluded that there was insufficient evidence to pursue a criminal investigation, and no charges for gross misconduct were brought against him.

46. Prison managers at Hindley conducted an internal investigation of Officer A's actions on 19 December 2022. The investigation concluded that he would be issued with advice and guidance.

Post-mortem report

47. The post-mortem report gave Mr Khan's cause of death as sepsis, pneumonia, pulmonary thromboembolism, and peripheral gangrene (following a cardiac arrest) caused by diabetes mellitus, diabetic ketoacidosis, influenza A, ischaemic and hypertensive heart disease, and metastatic pancreatic cancer.

48. At the inquest held on the 2 May 2024, the Coroner concluded that Mr Khan died as the consequence of a combination of pre-existing, diagnosed naturally occurring diseases, recently diagnosed Pancreatic Cancer and recognised complications arising from the combined effects of Type two diabetes, a recent viral infection and associated idiopathic cardiac arrest.

Findings

Clinical care

49. The clinical reviewer concluded that the care Mr Khan received was not of the required standard and therefore not equivalent to what he could have expected to receive in the community.

50. Mr Khan was on a self-management plan for his diabetes. Mr Khan knew how to contact the healthcare team if his blood sugar readings were irregular. However, healthcare staff relied on Mr Khan to inform them of this. The clinical reviewer considered this was not the best plan for Mr Khan as he was on the maximum dose of oral medication and told the GP at Hindley that he had been carbohydrate loading, which he knew could affect his diabetes. Mr Khan did not raise any concerns about his blood sugar readings with healthcare staff, but his blood sugar readings showed consistent poor diabetic control.

51. On the 30 June 2022, the GP services at the prison did not share the irregular blood sugar readings that were taken with nursing staff and therefore the nurses did not act accordingly. The Head of Healthcare told us that Mr Khan was referred to the long-term condition's clinic for monitoring and oversight of both hypertension and diabetes, but the long-term clinic nurse was on maternity leave and therefore Mr Khan's care was being managed by the GP services at the prison. Mr Khan was last seen by the GP on 24 November 2022. Healthcare staff also failed to follow up the endocrinology referral that was also sent to the endocrinology team on 1 July.

52. The clinical reviewer could not say whether better monitoring of Mr Khan's diabetic control and follow-up of the endocrinology referral would have affected the outcome for him. However, she concluded that better monitoring of Mr Khan's blood sugar and ketone readings should have happened. The clinical reviewer considered that there were missed opportunities for further monitoring of Mr Khan's diabetic control. We recommend:

    The Head of Healthcare should ensure that there is prompt and effective communication between the GP services and the healthcare team to ensure alerts and triggers for prisoners are monitored appropriately.

The Head of Healthcare should ensure that healthcare staff complete a full set of clinical observations, including a NEWS2 score, when a prisoner requires a healthcare assessment, to ensure that patients who are deteriorating, or at risk of deteriorating will have a timely initial assessment by a competent clinical decision maker.

53. The clinical reviewer has made a recommendation about first and secondary health screens which we do not repeat here but which the Head of Healthcare will need to address.

Good practice

54. There was good communication between the healthcare team at Hindley and hospital staff after Mr Khan was admitted to hospital on 19 December 2022. The clinical reviewer also noted the face to face contact the Head of Healthcare had with Mr Khan during his time in hospital and the wider offer of support to Mr Khan's family.

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