Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Johncock, a prisoner at HMP Lewes, on 15 February 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

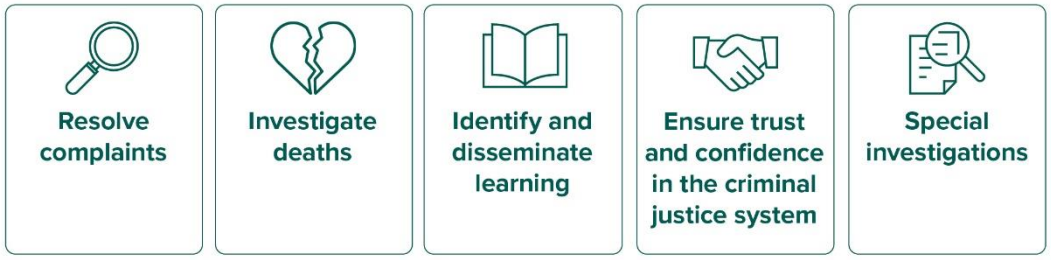
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Brian Johncock died in hospital on 15 February 2022, while a prisoner at HMP Lewes. He died after an operation to remove a tumour in his bowel. He was 82 years old. I offer my condolences to Mr Johncock's family and friends.

The clinical reviewer concluded that aspects of the care that Mr Johncock received at Lewes were not equivalent to that which he could have expected to receive in the community.

The clinical reviewer found that staff failed to recognise the deterioration in Mr Johncock's condition leading up to his admission to hospital on 4 February. She also considered that staff missed an opportunity to refer Mr Johncock under the suspected cancer pathway when he showed symptoms of possible cancer in November 2021.

Staff restrained Mr Johncock using an escort chain when he was taken to hospital on 4 February. I am concerned that the decision to restrain Mr Johncock, who was an elderly, unwell man, was not proportionate to the risk he posed.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **April 2023**

Contents

Summary

Events

1. Mr Brian Johncock arrived at HMP Lewes on 15 August 2019. He had several health conditions, including heart disease and diabetes, and he used a walking stick to get around as he had hip and back problems.

2. In November 2021, Mr Johncock told staff that he had blood in his stools. Mr Johncock provided a stool sample, but it was never analysed as the specimen container was overfilled. Staff ordered another test, but it did not arrive. It was not followed up.

3. By mid-January 2022, Mr Johncock was complaining of severe abdominal pain, vomiting and diarrhoea. Healthcare staff arranged blood tests and a stool sample to check for blood. The blood tests showed signs of infection and abnormal liver function, but the stool test was normal.

4. On 30 January, staff found Mr Johncock bent double in pain. He said he had vomited a bile-like substance and found eating painful. On 2 February, staff admitted Mr Johncock to the prison's inpatient unit for closer monitoring.

5. On 3 February, staff discharged Mr Johncock from the inpatient unit and moved him back to his cell. This was despite his blood pressure being very low.

6. The next day, a nurse reviewed Mr Johncock and recorded that his blood pressure was still low, his pulse rate was high, and his blood oxygen level was at the low end of the normal range. He asked a GP to see Mr Johncock. The GP found a lump in Mr Johncock's abdomen and sent him to hospital. Two officers accompanied him and restrained him using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist).

7. The next morning, a prison manager authorised the removal of the escort chain due to Mr Johncock's age and poor mobility.

8. Mr Johncock underwent surgery to remove part of his large intestine as doctors suspected a cancerous tumour. His condition subsequently deteriorated, and he died in hospital on 15 February.

Findings

9. The clinical reviewer found that aspects of the care Mr Johncock received at Lewes were not equivalent to that which he could have expected to receive in the community.

10. The clinical reviewer noted that in November 2021, Mr Johncock displayed some symptoms of possible cancer, and she considered it would have been prudent to refer him under the two-week cancer pathway at that point. She also noted that there had been a long delay in stool sample testing.

11. The clinical reviewer found that staff did not recognise Mr Johncock's clinical deterioration when he was in the prison's inpatient unit. She was concerned that he was discharged and returned to a standard wing when his blood pressure was very low. She considered that this was a poor decision. She also considered that use of the Multi-Professional Complex Case Clinic (MPCCC) might have enabled better management of Mr Johncock's declining health.

12. We consider that the use of an escort chain on Mr Johncock when he was taken to hospital on 4 February was inappropriate. Mr Johncock was 82 years old, was unwell and used a walking stick. The use of restraints on Mr Johncock was disproportionate to the risk he posed.

Recommendations

- The Head of Healthcare should remind staff how to order supplies.
- The Head of Healthcare should ensure that staff understand when they should make referrals under the suspected cancer pathway.
- The Head of Healthcare should ensure that staff understand how to assess clinical deterioration including use of the NEWS2 tool.
- The Head of Healthcare should ensure that staff are aware of the Multi-Professional Complex Case Clinic (MPCCC) criteria and consider its early use for a patient who is deteriorating.
- The Governor should ensure that authorising managers understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

15. NHS England commissioned an independent clinical reviewer to review Mr Johncock's clinical care at the prison.

16. We informed HM Coroner for East Sussex of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Johncock's next of kin, a friend, to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Johncock's friend raised concerns about the health care that Mr Johncock had received. These issues have been addressed in this report and in the clinical review.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out one minor factual inaccuracy which has been amended in this report.

19. We sent a copy of our initial report to Mr Johncock's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Lewes

20. HMP Lewes is a local prison serving the courts of East and West Sussex. Practice Plus Group provides primary care services. The prison has a healthcare centre with a full time senior medical officer. Healthcare is provided on a 24-hour basis. There is also a 9-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Lewes was in May 2022. Inspectors reported that around half of healthcare staff were agency or bank staff, which created risk and instability. However, dedicated staff demonstrated a commitment to the service, and the provider was taking all available steps to recruit substantive staff.

22. Inspectors reported that the inpatient unit provided good quality care to prisoners residing there, but staff shortages led to a restricted regime, with limited activities to support their well-being. The inpatient environment was inadequate, and some cells were in a poor condition, even though this had been highlighted at the previous inspection.

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 January 2021, the IMB noted that Practice Plus Group took over the provision of healthcare from Sussex Partnership Foundation Trust in April 2020 and had had a hugely beneficial impact on the healthcare provided at Lewes.

24. The healthcare provider had kept residents informed and clinics running throughout the pandemic, with waiting list times which the IMB considered to be no longer than those in the general community. There had been improved healthcare coverage during evenings and weekends and better out of hours prescribing.

Previous deaths at HMP Lewes

25. Mr Johncock was the tenth prisoner to die at Lewes since February 2020. Of the previous deaths, six were from natural causes and three were self-inflicted. There have been four deaths since, two from natural causes and two drug-related. In one of those investigations, we found that staff had not assessed clinical deterioration using the NEWS2 tool.

Key Events

26. On 15 August 2019, Mr Brian Johncock was sentenced to 12 years in prison for sexual offences. He was sent to HMP Lewes.

27. Mr Johncock had several health conditions including heart disease, diabetes and high blood pressure. He used a walking stick to get around as he had hip and back problems.

28. In November 2021, Mr Johncock said he had blood in his stools. Staff ordered a faecal immunochemical test (FIT) and asked him to collect a stool sample, which he did. However, the sample was never analysed as the specimen container was overfilled. Staff ordered another test, but it never arrived and was not followed up.

29. At the end of December, Mr Johncock told staff that he was having abdominal cramps and there was blood in his stools. He said that he was anxious about eating as it caused cramps. Healthcare staff said they would arrange another FIT test.

30. By mid-January 2022, Mr Johncock was complaining of severe abdominal pain. On 13 January, a nurse saw him and referred him for an urgent GP appointment. However, the GP could not see him the next day as the wing was in lockdown due to COVID-19. A nurse saw him on 15 January, and Mr Johncock complained of vomiting and diarrhoea. The nurse thought he might have gastroenteritis. The nurse gave Mr Johncock medication to treat diarrhoea and noted that Mr Johncock needed blood tests and a FIT test to check for blood in his stools. Healthcare staff checked on Mr Johncock daily. His condition improved but he said he had no appetite.

31. On 19 January, Mr Johncock complained of abdominal pain again. Staff took blood samples and realised that his FIT test had not been sent off (it was sent the next day). The blood test results were abnormal. They showed signs of infection and abnormal liver function. However, the FIT test result was normal.

32. On 30 January, staff found Mr Johncock bent double in pain. He told them he had vomited a bile-like substance, was off his food and found eating painful. Healthcare staff checked on him and found his vital signs were stable, but his blood pressure was low. They informed the GP.

33. On 1 February, healthcare staff decided that Mr Johncock should be admitted to the prison's inpatient unit for closer monitoring. He was admitted the next day. Staff carried out a range of tests, including another FIT test, and closely monitored his food and fluid intake.

34. Mr Johncock was discharged from the inpatient unit and moved back to his cell on 3 February. Healthcare staff noted that his blood pressure was low and should be monitored.

35. On the morning of 4 February, wing staff asked for a nurse to check on Mr Johncock as he seemed unwell. The nurse recorded that Mr Johncock appeared well and that the GP was aware of his low blood pressure.

36. Another nurse checked on Mr Johncock a few hours later. The nurse recorded that Mr Johncock's blood pressure was still low, his pulse rate was high, and his blood oxygen level was at the low end of the normal range. The nurse asked the GP to see him. When the GP examined Mr Johncock, he felt a lump in his abdomen. He sent Mr Johncock to hospital. Two prison officers accompanied Mr Johncock and they restrained him using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist).

37. The next day, a prison manager agreed to remove the escort chain due to Mr Johncock's age and poor mobility.

38. Mr Johncock underwent surgery to remove part of his large intestine as doctors suspected a cancerous tumour. However, his condition deteriorated in hospital, and he died on 15 February.

Contact with Mr Johncock's next of kin

39. On 6 February, when Mr Johncock was placed in a coma, the prison appointed a family liaison officer (FLO). The FLO contacted Mr Johncock's next of kin, a friend, to tell him that Mr Johncock was in hospital and to offer support.

40. The prison contributed to the costs of Mr Johncock's funeral in line with national policy.

Support for prisoners and staff

41. After Mr Johncock's death, a Custodial Manager debriefed the staff that were at the hospital when Mr Johncock died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Cause of death

42. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Johncock's cause of death as pneumonia, caused by emergency right hemicolectomy (an operation removing the right side of the colon and attaching the small intestine to the remaining portion of the colon) as a result of colorectal cancer with bowel obstruction.

Findings

Clinical care

43. The clinical reviewer found that Mr Johncock's long-term conditions were well-managed at Lewes, but other aspects of his care were not equivalent to that which he could have expected to receive in the community.

44. Healthcare staff recognised from their own internal investigation that the delay in testing the stool sample was not good practice as this may have presented a missed opportunity for further referrals. We recommend:

The Head of Healthcare should remind staff how to order supplies.

45. The clinical reviewer noted that in November 2021, Mr Johncock displayed some symptoms outlined in NICE (National Institute for Health and Care Excellence) guidance [NG12] Suspected cancer: recognition and referral, and that it may have been prudent to refer him under the two-week cancer pathway at that time. We recommend:

The Head of Healthcare should ensure that staff understand when they should make referrals under the suspected cancer pathway.

46. The clinical reviewer found that healthcare staff did not recognise Mr Johncock's declining health despite a rising NEWS2 score when he was in the prison's inpatient unit. (NEWS2 is a tool used to assess clinical deterioration in adult patients. A score is calculated based on the readings taken from clinical observations and the higher the score, the higher the clinical risk.) She was concerned that Mr Johncock was discharged from the inpatient unit despite his very low blood pressure, and she considered this was a poor decision given how unwell he was. She also considered that an earlier multidisciplinary meeting and use of the Multi-Professional Complex Case Clinic (MPCCC), held weekly to discuss patients who meet the criteria, may have enabled better management of Mr Johncock's declining health. We recommend:

The Head of Healthcare should ensure that staff understand how to assess clinical deterioration including use of the NEWS2 tool.

The Head of Healthcare should ensure that staff are aware of the Multi-Professional Complex Case Clinic (MPCCC) criteria and consider its early use for a patient who is deteriorating.

Restraints, security and escorts

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

48. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

49. The escort risk assessment noted that Mr Johncock was in poor health and had low mobility. Mr Johncock was also assessed as a low risk to staff and a low risk of escape. We consider that the use of restraints on Mr Johncock when he was taken to hospital on 4 February was not proportionate to the risk he posed. We recommend:

    The Governor should ensure that authorising managers understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Inquest

50. The inquest, held on 19 September 2024, concluded that Mr Johncock died from natural causes.

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