Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sidney Hughes, a prisoner at HMP Wymott, on 24 November 2023

A report by the Prisons and Probation Ombudsman

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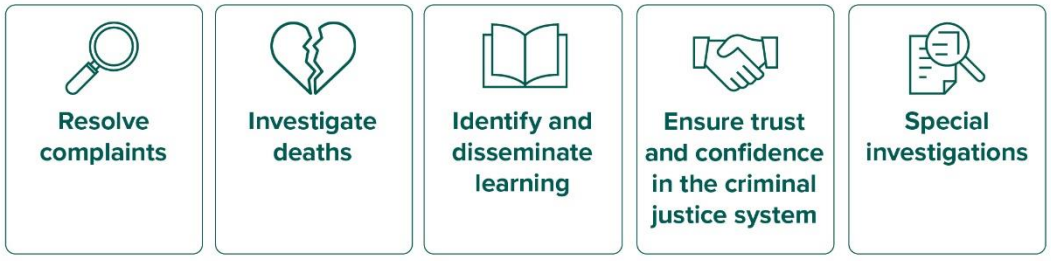
OUR VISION

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

Summary

1. 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.

2. 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.

3. Mr Sidney Hughes died from metastatic caecal adenocarcinoma (bowel cancer) on 24 November 2023, while a prisoner at HMP Wymott. He was 82 years old. We offer our condolences to Mr Hughes' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hughes received at HMP Wymott was of a good standard and equivalent to what he could have expected to receive in the community. However, she made a recommendation about ensuring reception health screens were completed in accordance with National Institute for Health and Care Excellence (NICE) guidance.

5. We found that there was a significant delay in the progression of the compassionate release application. Although the prison started the application promptly, the Community Offender Manager did not respond in a timely manner. Therefore, the application was not completed before Mr Hughes died.

Recommendations

- The Head of Healthcare at HMP Wymott should carry out an audit to assure themselves that secondary reception screenings are being completed in accordance with guidance, and report back to the Ombudsman within two months.

- The Head of Hertfordshire Probation Delivery Unit should ensure that Senior Probation Officers are aware of their responsibilities to allocate tasks relating to Early Release on Compassionate Grounds to a duty Community Offender Manager in a timely manner.

The Investigation Process

6. HMPPS notified us of Mr Hughes' death on 24 November 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Hughes' clinical care at HMP Wymott.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hughes' care.

9. The PPO family liaison officer wrote to Mr Hughes' son to explain the investigation and to ask if he had any matters he wanted us to consider. We did not receive a response.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Wymott

11. Mr Hughes was the seventeenth prisoner to die at HMP Wymott since November 2021. Of the previous deaths, 13 were from natural causes and three were self-inflicted. After Mr Hughes' death there was one natural cause death in 2023 which is still under investigation.

12. We have previously made recommendations to healthcare about ensuring that second reception screens are completed in accordance with NICE guidance. In a previous death, the Head of Healthcare agreed that all second stage assessments would be completed separately. In another investigation, the Head of Healthcare agreed to create and implement a new second reception ledger for staff to complete daily.

Key Events

13. On 21 December 2022, Mr Sidney Hughes was convicted of sexual offences and sentenced to 10 years imprisonment. He was 81 years old at the time of his conviction. He was sent to HMP Preston.

14. Prior to his conviction, in January 2020, Mr Hughes had been diagnosed with cancer (which was not terminal at that time). He underwent surgery in March 2020 and commenced chemotherapy thereafter. Following the completion of chemotherapy, Mr Hughes was scheduled to attend routine Computerised Tomography (CT) scans to monitor his condition.

15. On 12 January 2023, Mr Hughes was transferred to HMP Wymott.

16. Upon his arrival, healthcare staff saw Mr Hughes in Reception. It was noted that he suffered from Post Traumatic Stress Disorder and was on medication for this. Mr Hughes' cancer diagnosis was also noted.

17. On 26 January, Mr Hughes was moved to the Haven Unit at Wymott, which is exclusively for prisoners with additional care and support needs. This unit has a team of care workers and Mr Hughes was in a specially adapted cell for disability use.

18. Staff at Wymott arranged for Mr Hughes to attend hospital appointments with colorectal specialists. On 10 May, they diagnosed Mr Hughes with Stage 4 recurrent caecal adenocarcinoma with lung and abdominal lymph node metastatic cancer.

19. On 1 June, Mr Hughes said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

20. On 13 June, a specialist registrar from St Catherine's Hospice saw Mr Hughes. Records show that at this time he was still undecided about his preferred place to die.

21. On 29 August, Mr Hughes was transferred to HMP Preston for a period of assessment following his diagnosis of recurrent cancer. The assessment found that he had more social needs than health needs, despite his terminal diagnosis.

22. On 12 September Mr Hughes was transferred back to Wymott, and he reported that he was much happier.

23. Upon his arrival, healthcare staff saw Mr Hughes in Reception. It was noted that Mr Hughes had a DNACPR instruction with him and that he was bedbound due to poor mobility and recent falls. Mr Hughes was accommodated in a specially adapted cell for disability use on the Haven Unit. Healthcare staff did not complete a secondary health screen in line with the NICE guidance, as they should have done.

Compassionate release application

24. On 5 June, prison staff began the process for Mr Hughes' Early Release on Compassionate Grounds (ERCG). They requested reports from the hospital consultant, the GP at the prison, Mr Hughes' Prison Offender Manager (POM) and a Community Offender Manager (COM).

25. As Mr Hughes was in the early stages of his sentence, he did not have an allocated Community Offender Manager. Prison staff sent the COM report to a Senior Probation Officer (SPO) in Hertfordshire Probation Delivery Unit for allocation and completion.

26. On 6 July, the SPO responded to the request and said that the COM report could not be completed without further details from the GP. It was agreed that prison staff would send a copy of the GP report to the SPO once received.

27. On 7 July, Mr Hughes' POM completed her ERCG report and, on 15 August, a GP at the prison completed her ERCG report.

28. On 23 August, prison staff sent a copy of the GP report to the SPO. They did not receive a response from her, so sent further emails requesting an update on the status of the report on 19 September, 11 October and 17 November.

29. On 13 November, the hospital consultant oncologist completed their ERCG report.

30. On 17 November, prison staff received a response from the SPO. She said that Probation still did not have sufficient information regarding Mr Hughes' treatment pathway. She allocated the report to a COM for completion.

31. On 17 November, the COM attempted to contact the POM to discuss Mr Hughes' ERCG application. However, she contacted the prison family liaison officer (FLO) instead in error. Records show that there was no further communication between Hertfordshire Probation and the prison regarding Mr Hughes' ERCG application.

32. On 24 November, a Healthcare Support Worker conducted an overnight health and welfare check. Mr Hughes was observed completely motionless, and no pulse was present. The paramedic crew arrived and were advised that Mr Hughes was receiving palliative care and had a DNACPR in place. They confirmed that Mr Hughes had died.

Cause of death

33. The coroner accepted the cause of death provided by a prison doctor and no post-mortem examination was carried out. The doctor gave Mr Hughes' cause of death as metastatic caecal adenocarcinoma (bowel cancer). Mr Hughes also had primary dilated cardiomyopathy (heart disease) which contributed but did not cause his death.

Clinical Findings

Reception Screenings

34. National Institute for Health and Care Excellence (NICE) Guideline 57 covers the management of the physical health of people in prison. It states that in order to provide continuity of care, every prisoner should receive a health assessment to identify immediate health needs (before they are allocated to their cell), as well as a second-stage health assessment within seven days of their arrival.

35. The clinical reviewer noted that a secondary reception screening was not completed when Mr Hughes returned to Wymott in September 2023. She made a recommendation about ensuring reception health screens were completed in accordance with National Institute for Health and Care Excellence (NICE) guidance.

36. We have made similar recommendations previously regarding the completion of secondary reception screenings at Wymott, and on both occasions the Head of Healthcare has agreed actions. It is disappointing that the action plans are not being implemented as agreed and therefore we recommend:

    The Head of Healthcare at HMP Wymott should carry out an audit to assure themselves that secondary reception screenings are being completed in accordance with guidance, and report back to the Ombudsman within two months.

Non-Clinical Findings

Compassionate release

37. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

38. The Early Release on Compassionate Grounds Policy Framework also outlines that although there is no prescribed timeline for completing the applications it is imperative that applications are expedited as far as possible and those making the application should take account of the urgency of the case.

39. We sought further guidance from the HMPPS policy holder regarding this matter, who said that where a COM is yet to be assigned to the case, a duty COM must complete the ERCG report. Only if early release is granted should the case be allocated to a COM.

40. We found that there was a delay in the progression of Mr Hughes' ERCG application. HMP Wymott started the application promptly in June 2023. They initiated the paperwork and then sent requests to the hospital specialist, the GP at the prison, the POM and the community SPO, asking them to complete the relevant sections before returning the paperwork to the prison.

41. The task to complete Mr Hughes' ERCG report was not allocated to a duty COM in a timely manner, as it should have been, in June when the paperwork was sent to the community SPO. In July she requested further medical evidence from the prison, which they provided in August.

42. Despite the prison requesting updates from the SPO in September, October and November, they did not receive a response until 17 November. This delay by Probation in progressing the application meant the application was not completed before Mr Hughes died.

43. We asked the SPO to clarify the reason for this delay. She said that initially the prison did not send any information regarding Mr Hughes' medical condition and, once they did, she was still not satisfied that she had all the relevant information. She also said that she was on a period of leave in October 2023, and the request for an update from the prison was not escalated to her out of office contact.

44. We consider that had the SPO allocated Mr Hughes' ERCG report to a duty COM when she first received the application, this would likely have allowed the application to progress more quickly.

45. We recommend:

The Head of Hertfordshire Probation Delivery Unit should ensure that Senior Probation Officers are aware of their responsibilities to allocate tasks relating to Early Release on Compassionate Grounds to a duty Community Offender Manager in a timely manner.

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

At the inquest held on 17 July 2024, the Coroner concluded that Mr Hughes died of metastatic caecal adenocarcinoma.

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