Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Melvin McFadden, a prisoner at HMP Northumberland, on 12 March 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 HM Prisons 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 Melvin McFadden died in hospital on 12 March 2023, while a prisoner at HMP Northumberland. He was 73 years old. The cause of his death was kidney and heart failure caused by kidney cancer. He also had underlying hypertension and colon cancer. We offer our condolences to Mr McFadden's family and friends.

4. The clinical reviewer concluded that the clinical care Mr McFadden received at Northumberland was of a good standard and equivalent to that which he could have expected to receive in the community. However, she made recommendations on the need for clinical observations to be taken during medical assessments; and for healthcare staff to obtain daily updates when a prisoner is an inpatient in hospital.

5. We consider that the decision to restrain Mr McFadden when he was taken to hospital was not justified given his age and poor state of health, neither was it appropriate for restraints to be used during chemotherapy at previous outpatient appointments.

Recommendations

- The Director should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the prisoner's health; are based on the actual risk the prisoner presents at the time; and are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

- The Operational Security Group Director for HMPPS should monitor, over the next three months, how many prisoners at HMP Northumberland are escorted to hospital without restraints (for inpatient admissions and outpatient appointments) and report back to the Ombudsman.

The Investigation Process

6. HMPPS notified us of Mr McFadden's death on 13 March 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr McFadden's clinical care at HMP Northumberland.

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

9. The PPO family liaison officer wrote to Mr McFadden's next of kin, his daughter, to explain the investigation and to ask if she had any matters for the investigation to consider. Mr McFadden's daughter asked if healthcare staff had followed up her father's concerns about his breathing difficulties, swollen legs and stopping his blood pressure medication (and whether this had impacted on his health). These issues have been addressed in the clinical review report.

10. Mr McFadden's daughter received a copy of the initial report. She did not report any factual inaccuracies.

11. We shared the initial report with HM Prison and Probation Service. They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan has been annexed to this report.

Previous deaths at HMP Northumberland

12. Mr McFadden was the eighteenth prisoner at Northumberland to die since March 2020. Of the previous deaths, ten were from natural causes, six were self-inflicted and one was due to substance misuse. There have been three further deaths from natural causes.

13. We have previously made a recommendation about security risk assessments and the inappropriate use of restraints. Northumberland undertook to provide training for those involved in completing such assessments, as well as a briefing for healthcare staff. They also intended to quality assure ten per cent of completed risk assessments and discuss the findings at safer prisons and security meetings chaired by the Director and Deputy Director, respectively.

Key Events

14. Mr Melvin McFadden was remanded to prison on 22 July 2011 and was later convicted of sexual offences. On 21 December, he was given an indeterminate sentence, with a minimum period to serve of three years.

15. Mr McFadden's medical conditions included gout and longstanding hypertension (high blood pressure).

16. Mr McFadden transferred from HMP Holme House to HMP Northumberland on 9 September 2013. He did not fully engage with the reception and secondary health screens and declined most of the assessments, such as the NHS health check to detect early signs of chronic conditions, such as kidney disease.

2021

17. On 29 April 2021, a stool sample from Mr McFadden, tested under the Bowel Cancer Screening Programme, showed abnormalities. Mr McFadden was referred for additional assessments, but he declined further tests and investigations, including a colonoscopy. The GP and nurses at the prison repeatedly spoke to him about the risks of refusing and the possibility that he might have cancer, but he persistently declined.

18. A referral was made to Macmillan Cancer Support. A Macmillan nurse held an introductory meeting with Mr McFadden on 13 August and then saw him regularly. Over the following months, healthcare staff reviewed Mr McFadden weekly and took blood tests.

2022

19. In January 2022, ultrasound scans revealed masses in both kidneys and Mr McFadden agreed to be referred urgently to a specialist, under the NHS pathway for suspected cancer. Blood tests were taken, as well as CT scans of his chest, abdomen, pelvis and both kidneys.

20. On 9 March, a consultant urologist confirmed that Mr McFadden had terminal kidney cancer. A nurse at the prison discussed the diagnosis with him that day. On 10 March, the consultant told him that his cancer was incurable and his treatment would be palliative only, to relieve the symptoms. Healthcare staff completed a detailed assessment of Mr McFadden's care needs and the complex care team discussed him twice a month. At that time, it was too soon to give a prognosis of his life expectancy.

21. In June, Mr McFadden began oral chemotherapy. The pharmacist at the prison talked to him about the treatment cycle and possible side effects.

22. On 22 July, a consultant oncologist told Mr McFadden that there was a shadow in his sigmoid colon (the last section of the bowel, attached to the rectum), which needed further investigation.

23. On 28 October, Mr McFadden was informed by the hospital that the tumour in his kidney had grown and there was another mass. He re-started chemotherapy.

2023

24. On 4 January 2023, Mr McFadden had a scan which showed a mass in his sigmoid colon. He was immediately told that he had colon cancer. As he was asymptomatic, it was decided that he should continue with his existing palliative chemotherapy and treatment for the bowel cancer would be reviewed if he developed symptoms.

25. On 2 March, Mr McFadden had an outpatient appointment at Freeman Hospital, for cancer treatment. He was escorted by two prison officers. Single handcuffs were used, which were replaced by an escort chain during treatment.

26. While Mr McFadden was at the hospital, a GP at the prison received the results of a blood test that had been requested the previous day. As the results showed abnormalities, he immediately informed Mr McFadden's hospital consultant. After Mr McFadden's planned treatment, he had further tests and was diagnosed with cellulitis. He was then admitted as an inpatient and treated with intravenous antibiotics. The handcuffs were removed at 6.15pm on 3 March.

27. On 5 March, the prison informed Mr McFadden's daughter that Mr McFadden was in hospital. The escort staff facilitated telephone calls between them and prison managers later gave permission for visits.

28. Overnight on 8/9 March, Mr McFadden deteriorated suddenly and hospital doctors believed his condition to be terminal. It was agreed that he would not be resuscitated if his heart or breathing stopped and the hospital asked to speak to his next of kin. Mr McFadden spoke to his daughter after he was given the diagnosis. It was noted that a prison manager would appoint a family liaison officer.

29. At 8.55pm on 12 March, the prison's family liaison officer introduced herself to Mr McFadden's daughter. They discussed his condition and the processes in the event of his death. Mr McFadden died three hours later, at 11.55pm and the family liaison officer informed his daughter shortly afterwards.

30. The prison contributed to the costs of Mr McFadden's funeral, which was held on 27 March.

Post-mortem report

31. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr McFadden's cause of death as renal and cardiac failure, due to metastatic kidney cancer. Hypertension and colon cancer also contributed to but did not cause his death.

32. The inquest, held on 6 December 2023, concluded that Mr McFadden died from natural causes.

Non-Clinical Findings

Restraints, security and escorts

33. 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 account of health and mobility.

34. 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.

35. Mr McFadden was a category C prisoner, on the enhanced level of the prison's privileges scheme. The medical section of the security risk assessment for his appointment on 2 March, indicated that he was due to receive chemotherapy or life-saving treatment; and that there was no objection to the use of restraints, but they would need to be removed for treatment.

36. Mr McFadden was assessed as low risk on security aspects, such as the risk of escape and the likelihood of outside assistance to do so. The decision was that single handcuffs should be used, which should be reduced to an escort chain during treatment, "*if requested by a medical professional.*" A review of Mr McFadden's risk took place the day after he was admitted as an inpatient and it was decided that restraints were unnecessary, due to his age, poor health and mobility.

37. HMPPS' *Prevention of Escape – External Escorts Policy Framework*, encourages sensitive handling when considering the use of restraints, to ensure that the needs of security are balanced against the clinical needs of a seriously ill prisoner. It explicitly states that, *"the use of restraints on a prisoner receiving chemotherapy (or other lifesaving treatment) is degrading and inhumane, unless justified by other relevant considerations".* In addition, it says that restraints should not be used when mobility is severely limited due to advanced age, or disability, unless there is intelligence to suggest that an escape attempt might be made.

38. Use of restraints during Mr McFadden's invasive cancer treatment indicates either a lack of awareness, or deliberate disregard of the policy. The Ombudsman has repeatedly criticised HMPPS culture on this issue as being too risk averse and there not being a sufficiently strong body of evidence to support that aversion.

39. In response to previous recommendations to Northumberland, the Director proposed several measures to address this issue, such as training staff and auditing risk assessments. We are concerned that they have not been effective. We recommend:

The Director should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the prisoner's health; are based on the actual risk the prisoner presents at the time; and are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

The Operational Security Group Director for HMPPS should monitor, over the next three months, how many prisoners at HMP Northumberland are escorted to hospital without restraints (for inpatient admissions and outpatient appointments) and report back to the Ombudsman.

Director to note

40. Prison Service Instruction (PSI) 64/2011, about safer custody, states that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill. In addition, the PSI and Prison Rule 22 says that a prisoner's next of kin should be informed immediately if they become seriously ill, or if there is an unpredicted or rapid deterioration in their physical health. Northumberland did not comply with these policies.

41. When Mr McFadden was admitted to hospital, his condition was not initially thought to be life-threatening. However, given that he was already terminally ill, we consider that the prison staff should have exercised their discretion to notify his daughter as soon as he became an inpatient and it became clear that he would be in hospital for more than a day.

42. After he deteriorated significantly on 9 March and prison staff knew that he was likely to die, there should have been greater urgency in either appointing a family liaison officer, or another point of contact at the prison, to provide information and support.

43. The prison said that during the COVID-19 pandemic, information sharing between the healthcare provider and operational staff was poor. However, they felt this had greatly improved, particularly in instances of prisoners with terminal or serious illness.

44. As contact with prisoners' families is an issue we have raised previously, we hope that this improvement is sustained.

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

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