

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man, a prisoner at
HMP Holme House, in January 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, a prisoner at HMP Holme House, who died at hospital in January 2013. He was 63 years old. The cause of death was established by post-mortem as metastatic bronchogenic carcinoma (lung cancer that has spread to other parts of the body). I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer. Both HMP Holme House and HMP Northumberland cooperated fully with the investigation.

The man died a week after moving from HMP Northumberland to Holme House, and only a day after it was confirmed that he had lung cancer. In these circumstances, the investigation has examined whether his cancer might have been diagnosed at an earlier stage. I conclude that his symptoms were managed appropriately and, although one test could have been completed earlier, there is nothing to suggest this had any significant impact on the outcome. Nevertheless blood tests should be carried out in line with GP instructions and more attention ought to have been paid to his use of prescribed medication. I also consider that better arrangements could have been made to keep the man's wife, who was also in prison, informed of his condition in the final days of his life.

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

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Prisons and Probation Ombudsman

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CONTENTS

Summary

The investigation process

HMP Northumberland

HMP Holme House

Key events

Issues

Recommendations

SUMMARY

1. The man was sentenced to prison on 7 March 2012. He reported a headache to healthcare staff at HMP Northumberland on 19 September 2012. Over the next three months he told prison doctors and nurses on several occasions that the pain in his head and neck was getting worse. He was diagnosed with muscular pain, and prescribed anti-inflammatory medication to supplement the painkiller he already took for long-standing back pain. The man often took more than the prescribed dose, which meant that he sometimes ran out of medicine before he was due to receive a new supply and that the impact of the medication was not as effective as it should have been. We recommend that a risk assessment for in-possession medication is carried out when a prisoner is found not to be using opiate based medication correctly.
2. Blood tests taken in early November showed that the man's haemoglobin level was below the normal range. (Haemoglobin is a protein in red blood cells that carries oxygen around the body.) A prison doctor asked that the tests be repeated, and that additional tests to check ferritin levels be carried out (to measure the amount of iron in the blood). Although his haemoglobin level was checked, and continued to fall, it was some time before the ferritin level was tested. We recommend that blood tests are carried out in accordance with GP instructions.
3. At the beginning of December the man was referred for tests at a local hospital because his haemoglobin levels were low. A chest X-ray showed features that might indicate lung cancer and he was referred for further tests. In the meantime, his health deteriorated and it was agreed that he would move to the healthcare inpatient unit at HMP Holme House. He moved to Holme House on 15 January 2013, and had a more detailed scan that day. The result of the scan was received at Holme House on 21 January, and confirmed that he had cancer of the lung. The man's condition deteriorated significantly that day and he was admitted to hospital. He died the following morning, 22 January.
4. The man experienced pain in his head and neck for some time. The clinical reviewer comments that these were difficult to manage but concludes that his symptoms were treated appropriately. The delay in testing the man's ferritin levels might have resulted in a short delay to his eventual referral, but the clinical reviewer concludes that this would not have had a significant impact on his future care.
5. There are additional lessons that might be learnt at both Northumberland and Holme House including the inappropriate use of restraints in hospital when the man was frail, unwell and with reduced mobility. Better arrangements should have been made to allow him to communicate with his wife, a prisoner at HMP Low Newton, after his move to Holme House and to keep her informed of his condition.

THE INVESTIGATION PROCESS

6. On 22 January 2013, notices were issued at HMP Holme House and HMP Northumberland announcing the investigation to staff and prisoners, inviting anyone who had relevant information to contact the investigator. No one came forward.
7. The investigator visited Holme House on 25 January. During the visit, he saw the healthcare inpatient unit where the man lived. He spoke to the Head of Healthcare, a nurse who knew the man, and the prison's family liaison officer. He obtained copies of the man's prison records, including his medical record.
8. The investigator returned to Holme House on 11 March and interviewed three members of staff. He visited HMP Northumberland on 12 March, and interviewed a prison doctor and three prisoners who knew the man.
9. A clinical reviewer carried out a review of the man's clinical care in custody on behalf of the local PCT.
10. One of the Ombudsman's family liaison officers telephoned the man's wife, his nominated next of kin, on 14 February, to explain the investigation. The family liaison officer and the investigator met the man's wife on 22 February when she raised several issues that she wished the investigation to address. A number of her questions were factual in nature (for instance, the date her husband was first taken to hospital, and whether any X-rays were taken) which we have answered in the 'Key Events' section of the report. She believed she should have been kept better informed about her husband's health and the reasons for his move to Holme House. She also identified the following issues for the investigation to consider:
 - Were her husband's symptoms recognised and treated appropriately at HMP Northumberland and were appropriate referrals made to local hospitals?
 - The prisons should have been aware that her husband had a previous heart condition, and he should therefore have been provided with better care.
 - Despite being in terrible pain, her husband's painkillers were taken from him at Northumberland.
 - Should her husband have been admitted to hospital rather than transferred to HMP Holme House?
11. As part of the consultation process, the man's wife received a copy of the draft report. She commented on various aspects of the clinical care her husband received in prison, the inappropriate use of handcuffs, and the contact with her during her husband's illness. We have considered the issues raised and addressed these outside of this report in separate correspondence to her. The report was also sent in draft to the Prison Service.

HMP NORTHUMBERLAND

12. HMP Northumberland is an amalgamation of two prisons: Acklington and Castington and holds up to 1,348 sentenced adult male prisoners. The man lived in a houseblock that was part of the vulnerable prisoners' unit, in the former Acklington site.
13. Healthcare at the prison is provided by private healthcare provider. There are nurses on duty during the day, seven days a week. An out of hours' service is available at all other times. There are no inpatient facilities.

HM Inspectorate of Prisons (HMIP)

14. HMIP conducted an unannounced inspection of Northumberland in June 2012. The Inspectorate found that prisoners had good access to GP services and there was good care for prisoners with life-long conditions. Inspectors also found that there was an end of life policy in place, based on the Macmillan cancer support approach.

Independent Monitoring Board (IMB)

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. There is no current published IMB report for the newly amalgamated prison, but the last report for Acklington for 2010/11 noted that there had been some initial problems with the handover of the healthcare provision to the private healthcare provider, but these had settled down. The IMB welcomed the appointment of an experienced manager in charge of healthcare.

Previous deaths at HMP Northumberland

16. Four prisoners have died at HMP Northumberland since the prison was formed, two from natural causes. We found that these men received a good standard of medical care for the life-long conditions with which they had been diagnosed.

HMP HOLME HOUSE

17. Holme House is a local prison for up to 1,212 male adult prisoners. The majority of its prisoners are remanded into custody or recently convicted by courts in the local area. The prison also holds a small number of young adults aged 18 to 21.
18. Health services at Holme House are commissioned by the NHS and provided by a private healthcare provider. Nurses are on duty 24 hours a day and there are GP clinics six days a week, and out of hours cover. There is a 28 bed inpatient unit consisting of a mixture of single and double cells. The man lived in a single cell on this unit during his week at Holme House.

HM Inspectorate of Prisons (HMIP)

19. HMIP conducted a full unannounced inspection of Holme House in July 2010, and found that health services were undergoing substantial change. HMIP found that admissions to the inpatient unit were clinically appropriate, and inpatients had access to extended periods out of their cells and various activities. The inpatient unit was described as stark but adequate. Inspectors noted that primary care services and support for prisoners with lifelong conditions were good. There was an end of life policy and, when required, joint working with a local hospice.

Independent Monitoring Board (IMB)

20. The most recent IMB report for Holme House noted significant problems when the private healthcare provider took over healthcare provision in April 2011. In particular, they were not always able to provide the allocated number of GP sessions, and many prisoners made complaints about unexplained changes to their medication. However, the IMB found that healthcare staff had been able to overcome most of these problems and return the service to its previous high standard.

Previous deaths at HMP Holme House

21. The man was the sixth of seven prisoners to die at Holme House since December 2011. Four of these six men died of apparent natural causes. We found that those men who died at Holme House and who had a number of lifelong conditions received a good standard of care. However, in one case we judged that restraints were inappropriately used on an older, frail man when he was admitted to hospital.

KEY EVENTS

22. The man was sentenced to eight years imprisonment on 7 March 2012, and arrived at HMP Durham on the same day. Other than a brief spell in custody in 1970, this was his first time in prison. He was 62 years old. At a reception health screen, the man told a prison nurse that his medical history included ischaemic heart disease (caused by reduced blood supply to the heart), angina and depression. He also said he smoked 20 cigarettes a day. Later in the evening, he told a prison doctor that he had had a heart attack five years earlier. Healthcare staff contacted the man's community GP, who confirmed his medical history and medication, which included various medications for heart disease, an antidepressant, and dihydrocodeine (pain relief for moderate pain) for back pain which he said he had experienced for several years.
23. The man reported no significant medical problems at Durham, and moved to HMP Northumberland on 13 April. A nurse saw him when he arrived and noted his medical history. He was allowed to keep his medication in his cell to take as prescribed.
24. In July, the man reported recent chest pains and was prescribed additional angina medication. Later in the month, he attended the prison's clinic for older prisoners, at which it was recorded that he was fully mobile "in his own time". The man's blood pressure was recorded as 77/54, significantly lower than the normal range¹. No follow-up measures, such as a repeat of the reading, appear to have been arranged.
25. The man reported a headache on 19 September, and was given ibuprofen by a prison nurse. This is the first recorded time that he spoke of headaches to healthcare staff at the prison, although his wife told our family liaison officer that he told her in a letter to her in August that he had been experiencing pain. There is no record that the man told the nurse on 19 September that he had had previous or ongoing headaches.
26. After telling a nurse on 7 October that he continued to experience headaches, the man saw a prison doctor on 11 October. He told the doctor that he had had headaches for over two weeks, and was now also feeling nauseous. He said the pain started at the top of his neck and limited its movement. The doctor prescribed naproxen (an anti-inflammatory medication).
27. On 30 October, the man saw another prison doctor and said he was still in pain. He said he had never experienced similar pain before, and had limited movement in his neck. After examining his neck, the doctor diagnosed muscular pain and asked him to return if it did not improve. The doctor told the investigator that such symptoms are usually due to muscular pain. He added that it would not be usual to refer the patient to hospital at this stage unless there were any 'red flag' symptoms which might suggest a more

¹ Ideal blood pressure is between 90/60 and 120/80

significant underlying cause. The man did not have any such symptoms at the time.

28. The man's pain continued and he therefore saw a third prison doctor on 7 November. She also considered the pain to be muscular, and made a referral for physiotherapy. The same day, a check of his medication revealed that some of the man's prescribed medication, including dihydrocodeine, was missing. The doctor asked for a urine test to be taken, the results of which showed that he had not taken dihydrocodeine. She therefore asked that no more dihydrocodeine be issued.
29. After a routine blood test, which showed a drop in his haemoglobin² level, the man saw a doctor for a review on 13 November. The doctor examined him and asked him about issues that might be related to this drop (such as a change in his bowel movements) but could find no obvious cause. The doctor asked that the blood tests be repeated, with an additional test for ferritin levels. He explained at interview that it is standard to repeat such tests to determine whether the low haemoglobin is an ongoing issue. He said that a low ferritin level might suggest internal bleeding and would, in combination with low haemoglobin, lead to a referral for further investigation.
30. On 22 November, the man told a prison nurse that his recent urine test was negative because he had previously taken more of his medication than he should have and had therefore run out of it by the time of the test. He said he still had a pain in his neck, and asked for dihydrocodeine to be prescribed again. After a medication review by a prison doctor, dihydrocodeine was reissued to the man.
31. The man saw a doctor to review his neck pain on 27 November. He told the doctor that he was not taking naproxen, the anti-inflammatory he had been prescribed, as it was "not a painkiller". The doctor examined the man and repeated his previous diagnosis of muscular pain. The doctor encouraged him to take his prescribed medication.
32. Towards the end of November, and in early December, the man told prison nurses that the pain in his neck was getting worse. He again began to take more dihydrocodeine than the prescribed dosage, and a review was therefore arranged with a GP for 3 December. The man told the doctor that the pain had been worse for around ten days. The doctor warned him of the dangers of excessive use of dihydrocodeine and prescribed paracetamol for him to use as required when his pain increased. The doctor also made a second referral for physiotherapy.
33. The next day, a member of staff in the workshop in which the man was employed telephoned the healthcare centre and said that he was no longer fit enough to operate the machinery. On 5 December, he was formally signed off from having to work, due to ill health.

² Haemoglobin is a protein found in red blood cells that carries oxygen around the body.

34. The results of the man's follow up blood test were available on 4 December, and showed a continued fall in his haemoglobin level. The test for ferritin requested by a doctor on 13 November had not been completed. He therefore asked that another sample be taken and the tests repeated. An appointment was made to discuss the results of the first test with a doctor on 6 December but, on the day, he said he did not wish to attend.
35. The doctor discussed the results of the additional blood test with the man on 18 December. His ferritin level had still not been tested. The doctor noted that the man's haemoglobin level had continued to fall. He examined the man but found no obvious symptomatic cause. The doctor made an urgent referral to hospital for a colonoscopy (internal examination of the colon), ultrasound of the abdomen and chest X-ray, to try to establish a cause. The doctor noted that he did not make this referral under the two week rule for suspected cancer as the man did not have any obvious bowel or stomach symptoms. (The two week rule is a national target for patients with suspected cancer to be seen by a consultant within two weeks.) The man was told of the referral and the reasons for it.
36. Over the following days, the man's health deteriorated and his records show that his headaches were now more painful and he was not eating properly. On 22 December, he was admitted to hospital due to this deterioration. He remained in hospital overnight and had various tests, including a computerised tomography (CT) scan of his head and the chest X-ray requested by the doctor a few days earlier. The CT scan showed nothing abnormal, but the chest X-ray showed what was described as a "bulky hilum" (the hilum is the central part of the lung where blood vessels enter). An underlying cancer was one possible reason for this. The man was asked to return for further tests, including a CT scan of his chest and a magnetic resonance imaging (MRI) scan of his brain.
37. The appointment for the man's MRI scan was initially arranged for 3 January 2013, but was cancelled by the hospital and rearranged for 11 January. However, the man was admitted to hospital on the morning of 3 January as he was in significant pain, had not eaten for some time and was described as appearing "very frail". He returned to prison during the night, having been prescribed ibuprofen in addition to his existing pain relief.
38. On 4 January, an inspection of the man's medication indicated that he had not been taking it as prescribed. It was therefore decided that his medication would, in future, be supplied by a monitored dosage system³. It was also agreed that a nurse would visit him each morning to prompt him to take his medication and monitor the previous day's compliance.
39. As a result of the man's deterioration, a case conference was held on 4 January to produce a plan for his future care. The conference was attended by representatives from the prison healthcare department and his wing. It

³ A monitored dosage system (MDS) is a way of packaging medication so it is separated into slots by day and time. The main advantage is to help patients take the right medication at the right time, but it also allows healthcare professionals to more easily monitor the patient's compliance.

was agreed that the man would move to a cell on a different unit which had aids fitted to help men with reduced mobility. It was also agreed that the nurse visiting him each morning would assist him with his personal care. A prisoner⁴ was appointed to help the man, and it was agreed that he would be given nutritional drinks that would be easier for him to digest. He was also referred to local palliative care services for assessment.

40. The final decision of the case conference was that the man's next of kin should be contacted and told of his condition. The man was consulted and he asked that only his wife should be contacted. His wife was in prison and, later on 4 January, a family liaison officer contacted her counterparts at HMP Low Newton and explained that the man was unwell. They agreed that a member of staff at Low Newton would speak to his wife.
41. The man attended an outpatient appointment with a bowel specialist on 7 January, accompanied by a prison nurse. It was agreed that he would return as an inpatient for the planned colonoscopy. He was later given an admission date of 5 February for this procedure.
42. A local Macmillan nurse visited the man on 8 January, and reviewed him with a doctor and a prison nurse. It was noted that his likely diagnosis was cancer. The man said he was still experiencing headaches, and his painkilling medication was therefore changed to tramadol (for moderate to severe pain). On the same day, the doctor noted that his blood had now been tested for ferritin, which was within the normal range.
43. A multi-disciplinary meeting was held on 9 January, involving a range of prison staff. Due to the recent deterioration in his health, they agreed that, following the CT scan of his chest that was arranged for 15 January, the man would transfer to the healthcare inpatient unit at Holme House. Staff at Holme House made the arrangements and the healthcare manager wrote to the hospital to ask that the man's care be transferred to another hospital closer to Holme House.
44. The man's health did not improve in the following days, and he continued to eat and drink very little. He went to hospital on 11 January for a pre-arranged MRI scan of his head but was too unwell to have the scan when he arrived.
45. Two days later, healthcare staff sent the man to hospital, as they were concerned that he was dehydrated. He returned later in the afternoon, after being diagnosed with a chest infection and prescribed antibiotics.
46. The man returned to hospital on 15 January, for his planned CT scan. A risk assessment is usually carried out before all hospital appointments, to assess what security arrangements, including the use of restraints, are required. The risk assessment prepared for the appointment could not be found at either HMP Northumberland or HMP Holme House. Nevertheless, it is apparent

⁴ Some prisoners, who are assessed as suitable for the role, help those prisoners who require it with everyday activities such as cleaning their cell and collecting meals and hot water. These prisoners, known as buddies, are paid for carrying out the work.

from the escort record that the man was restrained using an escort chain⁵ and accompanied by two officers. The escort chain was removed for the scan. It was then reapplied for the onward journey to Holme House, where he arrived at around 12.15pm.

47. At a reception healthscreen at Holme House, a nurse noted the man's recent medical history. As agreed, he was admitted to a cell in the prison's healthcare inpatient unit. Later that afternoon, another nurse assessed the man and produced care plans to guide staff in monitoring and managing his care needs, including his food and fluid intake, mobility, and personal care. She described the man to the investigator as a "very frail, very unkempt man" who was determined in what he did and did not want to do.
48. After going outside to smoke on 17 January, the man told staff that he felt too weak to make it back to his cell and he was brought back in a wheelchair. Later that afternoon a prison doctor discussed him with the nurse who had assisted him. They observed that the man was finding it difficult to swallow his painkillers. The doctor stopped his tablet medication and instead prescribed a fentanyl patch⁶.
49. On 21 January, the prison received a letter from the hospital detailing the results of the man's CT scan a week earlier. The results confirmed that he had lung cancer which had spread to his shoulder blade and ribs. A prison doctor made a referral to another hospital (where his care had now been transferred) under the two week rule. He told the investigator that he made this referral as it was unclear from the letter whether any follow up had been arranged and he wanted to ensure that the man was seen quickly by a specialist.
50. Later that afternoon, the man's health deteriorated. An ambulance was called and he was given oxygen to help him breathe. As is standard, a risk assessment was completed while waiting for the ambulance to arrive. No details of the man's medical condition were given on the form, although in a separate note a nurse reported that he had a history of angina, chest pain, depression and he potentially had cancer. In the risk assessment, he was assessed as a medium risk of escape and to the public (on a scale of low, medium, high). The risk assessment was authorised by the Head of Residence, who concluded that an escort chain and two officers were the appropriate security measures.
51. The man's health deteriorated further after he arrived at hospital and staff had to resuscitate him. The escort chain was removed for this procedure and not reapplied. Escort staff consulted the duty governor, who decided not to contact the man's wife as he was aware that she had previously said she would end her life if her husband were to die. The man did not improve. He died at 6.45am.

⁵ An escort chain is a long chain with a handcuff at each end, one of which is attached to a prisoner and another to an officer.

⁶ A patch containing fentanyl, for severe pain, which is applied to the skin and provides continuous pain relief over a period of time.

52. A family liaison officer was appointed at Holme House immediately after the man's death. She telephoned Low Newton at 7.30am and told a senior officer that the man had died. A member of staff at Low Newton broke the news to his wife. Later that day, she was escorted to the hospital to formally identify her husband's body.
53. The man's funeral, which his wife attended, took place on 12 February. Holme House met the costs of the funeral in line with national guidance.

ISSUES

The diagnosis of the man's terminal illness

54. The man's wife asked whether her husband's symptoms were recognised and treated appropriately at Northumberland and whether he might have been diagnosed at an earlier stage. She also questioned whether his previous heart condition was recognised by prison healthcare services and, if not, whether this impacted on the quality of care he received.
55. The man's heart condition was identified at his reception health screen on arrival into prison on 7 March 2012. In line with Prison Service guidance, healthcare staff contacted his community GP, who faxed a summary of the man's medical history to HMP Durham in his first week at the prison. When he reported chest pain in July, changes were made to the man's medication and he made no further complaints of angina symptoms.
56. The man first reported a headache on 19 September and was given ibuprofen by a prison nurse. Although his wife told our family liaison officer that her husband had written to her in August and said that he had "terrible pains" in his head, there is no record that he told the nurse that he had experienced previous or persistent headaches.
57. Over the following weeks, the man reported ongoing head and neck pain and was assessed by prison doctors on a number of occasions. His symptoms were diagnosed and treated as muscular pain and he was prescribed painkilling medication. At interview, a doctor commented that symptoms such as this are usually caused by muscular pain and it would not be usual to refer the patient to hospital specialists without any other symptoms which would indicate concern.
58. Blood tests in early November showed that the man's haemoglobin level was below the normal range. A doctor asked that the blood tests be repeated and that the sample be tested to check his ferritin levels. A low ferritin level might indicate internal bleeding, and would therefore lead to a referral for further investigation. Although two further blood samples were taken in the next six weeks, the ferritin level was not tested on either occasion. Nevertheless, as the results of the tests showed the man's haemoglobin level continued to fall, the doctor made a referral to hospital specialists. The investigations undertaken after this referral led to a diagnosis of lung cancer.
59. The clinical reviewer comments that the man's head and neck symptoms were regularly reviewed and assessed. He concludes that these problems were difficult to manage but were, ultimately, treated appropriately. We note that the man's CT scan revealed that his cancer had spread to his shoulder blade, which raises the question of whether this was the underlying cause of the pain he was experiencing. The clinical reviewer concludes that the relationship between the man's symptoms and his final diagnosis remains unclear.

60. We do not believe there should have been such a delay in testing the man's blood for ferritin levels. However, when tested, the results were within the normal range. These results suggest that earlier testing of ferritin levels would not have led to an earlier referral. The clinical reviewer concludes that, even if there were a delay, this would not have had a significant impact on the man's future care. Nevertheless, we make the following recommendation:

The Head of Healthcare at HMP Northumberland should ensure that blood tests are carried out in accordance with GP instructions and the results are made available to clinicians in a timely manner.

Medication

61. When he arrived at HMP Northumberland, the man was assessed as suitable to keep his medication 'in-possession' in his cell. He was to collect new medication each month, except for dihydrocodeine which, due to its greater potential for misuse, he would collect each week.
62. It was reported on several occasions in autumn 2012 that the man did not take his medication as it was prescribed. His painkiller, dihydrocodeine, was stopped on 7 November when a urine test was negative for the medication, suggesting he had not used it. Two weeks later the man explained that the test had been negative because he had overused his medication and it had run out before the test. His dihydrocodeine was reissued after a medication review with a doctor.
63. There was additional evidence that the man continued to misuse his medication. He did not take his prescribed naproxen as he did not think it was a painkiller. There were also further occasions when he over-used dihydrocodeine to counter his pain. On the first occasion, he was warned of the dangers of misusing dihydrocodeine and was given paracetamol as an alternative if his pain increased. When his misuse continued in early January 2013, it was agreed that a nurse would visit the man each day to remind him of what to take and to check the previous day's compliance.
64. It is apparent that the man did not take his medication as was intended for some time. One reason for this is that he felt he needed additional painkillers, and therefore overused what was provided which meant that he then ran out of supplies. This is a concern as there are inherent dangers in taking additional opiate medication to that prescribed. He did not take naproxen because he did not understand the benefits.
65. Although a solution was found that enabled healthcare staff to monitor the man's use of medication more closely, this happened only after several incidents of misuse. There is no evidence that his risk to keep in-possession medication was reassessed appropriately, which we would have expected when he was re-prescribed dihydrocodeine in November 2012 and on other occasions when his consumption was questioned. It is also surprising that his dihydrocodeine was stopped earlier in the month without any indication that he was asked about the results of his urine test and given the opportunity to

explain them. There was no review to check that he was receiving sufficient pain-relief medication to treat his symptoms.

The Head of Healthcare should ensure that a medication review and risk assessment for in-possession medication is carried out whenever a prisoner is suspected of misusing opiate medication.

The man's location

66. The man moved from HMP Northumberland to HMP Holme House on 15 January 2013 because his health had deteriorated and it was agreed that he needed to be in a prison with 24 hour inpatient facilities. His wife was concerned that her husband should have been admitted to hospital rather than transferred to a different prison. At interview, a doctor explained that hospital admission was not given much consideration at this stage. He said that the man did not have any additional care needs at the time that could not be provided at Holme House and there had been no indication from hospital specialists that he required admission. A nurse at Holme House also told the investigator that she thought the prison was the appropriate place for the man at that time.
67. The man had several hospital appointments and admissions in December 2012 and January 2013, including an appointment on the day he moved to Holme House. At no point was his continued admission to hospital recommended by hospital specialists. We are satisfied that his move to Holme House was appropriate.

Liaison with the man's family

68. After a case conference on 4 January 2013, and consultation with the man, it was decided to contact his wife, his next of kin, to inform her of the deterioration in his health. A family liaison officer at Northumberland therefore contacted HMP Low Newton, where she was a serving prisoner, and a member of staff there spoke to her.
69. There does not appear to have been any further contact with the man's wife before her husband's death, although all involved in his case from the beginning of January considered that he had cancer. A prison doctor at Holme House told the investigator that this was a "strong suspicion" and there are several entries in his medical record in which staff discuss the likelihood that he had lung cancer. A letter of 21 January from the hospital confirmed that he had lung cancer, which had spread to his shoulder and ribs.
70. Prison Service guidance states that prisons must engage with the families of seriously or terminally ill prisoners, and encourage a terminally ill prisoner to do likewise. We agree that it was appropriate to contact the man's wife in early January 2013. Although he had not formally been diagnosed, his move to Holme House due to ill health was a significant event in his life and it was expected at the time that he had cancer. As he was recognised to be seriously ill, we think it would have been appropriate to contact his wife again

at this point and, if both were willing, arrange for her to visit her husband or for them to speak over the telephone.

The Governor should ensure that any seriously or terminally ill prisoners transferred to the inpatient healthcare unit at HMP Holme House are helped to have appropriate contact with their next of kin.

71. At around 1.00am on 22 January, shortly after the man had been resuscitated, hospital doctors asked the escort staff for his wife's contact details. The escort staff explained that she was also a serving prisoner and contacted the duty governor for advice. The duty governor told the investigator that he decided that the man's wife should not be contacted. He explained that this was because he had information that she might attempt to take her own life if her husband died. The duty governor said he did not therefore think it appropriate to share the information with the man's wife until the morning.
72. Although Prison Service guidance instructs that prisons should immediately inform the next of kin if a prisoner becomes seriously ill, these were unusual circumstances. We understand the duty governor's decision to wait until morning, when there would be significantly greater resources available at Low Newton to support the man's wife. However, it might have been preferable to speak to the duty governor at Low Newton, who would have greater knowledge of the man's wife and the resources available at the prison, and allow them to contribute to the final decision. Sadly the man died before his wife was told of his hospital admission, but she was told of her husband's death promptly on the morning of his death.

Restraints, security and bedwatch

73. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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 which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

Transfer and CT scan on 15 January 2013

74. The risk assessment prepared for the man's transfer from Northumberland to Holme House, via hospital, could not be found at either prison. Nevertheless it is clear from the escort record that an escort chain was used, which was removed for his scan. At the time, the man was clearly unwell, frail and had limited mobility. He was a category C prisoner (defined as those who cannot be trusted in open prisons but who are unlikely to make a determined effort to escape). Although he had recently been convicted of serious offences and sentenced to eight years imprisonment, the man's offences were committed over 35 years previously and the circumstances would not suggest that he was a current risk to the general public. We agree that it was right that the escort chain was removed for his scan, but also consider that his health was such that his risk for the escort could have been managed by escort staff alone without the use of restraints.

Emergency admission on 21 January 2013

75. A risk assessment was completed before the man's emergency hospital admission on 21 January. He was judged to be a medium risk to the public (on a scale of low, medium, high) and a medium risk of escape. No details of his medical condition were given on the form, although in a separate note his history of angina and chest pain were recorded, with the phrase "?cancer" indicating that he might have cancer. The specific circumstances of his admission, including his very limited mobility, were not mentioned. However, the duty governor, who authorised the risk assessment, told the investigator he was aware that the man would go to hospital in a wheelchair or on a bed. Despite this he decided that an escort chain would be used and two members of staff would make up the escort.
76. By then the man was very unwell. His breathing had deteriorated and he was unable to walk. Prison Service guidance is that restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. There is no evidence to suggest that he presented a risk of escape or to the public that could not have been managed by a two officer escort. We do not consider that the use of an escort chain to restrain him when he was taken to hospital was justified by a properly considered risk assessment.

The Governors of HMP Northumberland and HMP Holme House should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

RECOMMENDATIONS

To HMP Northumberland

1. The Head of Healthcare at HMP Northumberland should ensure that blood tests are carried out in accordance with GP instructions and the results are made available to clinicians in a timely manner.

Accepted

All clinical rooms to have detailed information available to all clinicians detailing the correct sample bottle to be used for specific blood tests.

The use of the task system by GPs when requesting blood tests to be implemented and co-ordinated by administration team.

All blood results returned via lab links are to be assigned and saved directly in medical records electronically.

2. The Head of Healthcare should ensure that a medication review and risk assessment for in-possession medication is carried out whenever a prisoner is suspected of misusing opiate medication.

Accepted

The issue of the man's use of medication and incorrect medication count was discussed at nursing handover. It was felt that due to no nursing availability overnight he would not be able to respond to his pain if medication was not in possession; therefore he was allowed to keep in possession. No formal documentation was initiated that justified this process. All clinical staff to be instructed in the event of incorrect medication count, clear documented evidence of decision making process to be documented within the medical records.

To HMP Holme House

3. The Governor of HMP Holme House should ensure that any seriously or terminally ill prisoners transferred to the inpatient healthcare unit from another establishment are helped to have appropriate contact with their next of kin.

Accepted

A system has been put in place to ensure where seriously or terminally ill patients are in healthcare, a family liaison officer will be allocated to ensure contact with next of kin is maintained.

To HMP Northumberland and HMP Holme House

4. The Governors of HMP Northumberland and HMP Holme House should ensure that risk assessments for prisoners taken to hospital fully take into

account individual circumstances and are based on the actual risk the prisoner presents.

Accepted

HMP Northumberland – Appropriate risk assessments are carried out for every escort that leaves HMP Northumberland. This risk assessment identifies the risk the prisoner poses to the public and the risk the public poses to the prisoner. Head of Security has reviewed the emergency escort/bedwatch risk assessment paperwork to ensure all aspects are correctly risk assessed. This has been passed onto all operational managers.

HMP Holme House – All managers will be made aware of ‘PPO Learning Lessons Bulletin – Fatal Incident Investigations Issue 2’ to ensure “levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by consideration of care and decency for the prisoner”.