PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at St Raphael's Hospice, Sutton in April 2013, while in the custody of HMP High Down

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 investigation report into the death of a man at St Raphael's Hospice in Sutton, Surrey, on 8 April 2013, while a prisoner at HMP High Down. The man was 55 years old and had been suffering from bowel cancer. I offer my condolences to his family.

The investigation was carried out an investigator. A clinical reviewer conducted a review of the man's clinical care at High Down. The prison co-operated fully with the investigation.

The man had been in High Down for just over three months when he saw a doctor in February 2013 about a lump, which he said he had had for some time. He was referred to hospital urgently, as the doctor suspected he had cancer. In March, the man had a biopsy followed by a colostomy. Bowel cancer was confirmed but was already widespread. He was returned to prison briefly but went back to hospital in early April when his condition deteriorated very quickly. He was moved to a hospice and died on 8 April.

The clinical reviewer concludes that the man's clinical care in prison was comparable to that he could have expected to receive in the community and that, overall, the support provided by staff at High Down to the man was good. However, I am not satisfied the risk assessment process for the use of restraints in hospital fully took into account the man's serious medical condition. It is also disappointing that the prison did not appoint a family liaison officer as soon as the man was diagnosed with a terminal illness, rather than waiting till after his death, especially given the predictable difficulties in communicating with his family in Nigeria.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

CONTENTS

SUMMARY

1. On 28 October 2012, the man, a Nigerian national, was arrested at Gatwick Airport for possession of drugs and a false passport. He was later sentenced to four years and four months in prison. On 8 February 2013, the man saw a nurse about an ongoing urine infection and told her that he had noticed a lump in his anus. A GP examined him five days later and made an urgent referral to hospital with suspected cancer.

2. A doctor at Epsom General Hospital saw the man two weeks later and noted that he had a two year history of rectal pain and bleeding after defecation. The man told the doctor he had been aware of the lump for the previous two years and that it had been increasing in size. After an examination and biopsy in mid-March, the man was diagnosed with bowel cancer. He had a colostomy but further tests and scans showed that the cancer had already spread to his liver and bones. He was discharged back to High Down on 29 March.

3. Over the next few days, healthcare staff at the prison chased up a palliative care referral and arranged for a specialist nurse to see the man. However, his condition deteriorated and he was sent back to hospital in the early hours of 3 April. Restraints were applied while he was taken to hospital, but were removed after a review.

4. The hospital medical team considered there was no further treatment to help the man and he was moved to St Raphael's Hospice on 5 April. The man spoke to his family in Nigeria and the doctor informed his wife of the gravity of the man's condition. The man died at the hospice in the early hours of 8 April. Communication with the man's family after his death was difficult and we consider a member of staff should have been appointed to liaise with them at an earlier stage when he was first diagnosed with a terminal illness.

5. The clinical reviewer considered that the man's medical care was in line with that which he could have expected to receive in the community.

6. We make recommendations about the risk assessment process for the use of restraints and about the appointment of a member of staff to liaise with families when a prisoner is seriously ill.

THE INVESTIGATION PROCESS

7. Notices were issued at High Down announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.

8. The investigator visited High Down on 12 April and collected documents relating to the man's time in custody. She returned to High Down from 14 to 16 May and interviewed three members of staff. She gave preliminary feedback on the findings of the investigation to the Governor.

9. Surrey Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care in prison. She was given all the relevant documents to assist her review.

10. A copy of the investigation report has been sent to HM Coroner for Surrey. Because the man's death was expected and entirely due to natural causes, the Coroner decided not to open an inquest into his death and there was no post-mortem examination.

11. One of the Ombudsman's family liaison officers contacted the man's family in Nigeria to let them know about the investigation. They did not identify any issues they wished the investigation to consider.

HMP HIGH DOWN

12. HMP High Down is a local prison near Sutton which holds around 1,100 male prisoners. Healthcare services at the prison are commissioned by NHS Surrey and provided by Virgin Care Services. There is a 23 bed inpatient unit.

Her Majesty's Inspectorate of Prisons

13. HM Inspectorate of Prisons (HMIP) last inspected High Down in July 2011 and judged that that healthcare provision was very good and supported by an impressive level and quality of staff. Prisoners were generally satisfied with their access to healthcare services. However, HMIP noted that provision needed to be improved for prisoners whose needs differed from the population as a whole because of their age, nationality or disability.

14. Inspectors found that there was no coordinated approach to managing foreign national prisoners. There were no forums to identify and discuss ongoing or emerging issues for the large foreign national population. Schemes to encourage foreign national prisoners to maintain ties with their families – including a free monthly telephone call in lieu of visits and airmail letters – were poorly publicised to staff and prisoners and were available inconsistently.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published annual report, the IMB at High Down was positive about the provision of healthcare and described it as "excellent with progressive improvements in all areas, despite budget constraints".

Previous deaths at High Down

16. We have investigated a number of deaths at High Down. An investigation into a death in 2011 recommended that a family liaison officer should be appointed when it is known that a prisoner is terminally ill and reaching the end of their life. A similar recommendation is made in this case.

KEY EVENTS

17. The man was born in 1957 and lived in Nigeria for most of his life. On 28 October 2012, he was arrested at Gatwick Airport and charged with possession of Class A drugs and having a false passport. After a court hearing on 29 October, the man was remanded into custody and taken to HMP High Down.

18. During his reception healthscreen, the man did not mention any particular physical or mental health problems. In November, he told a prison nurse that he sometimes felt out of breath when climbing the stairs. He told a GP that he experienced pain in his chest area on exertion. Some blood tests, liver function tests and an ECG were carried out. All came back normal.

19. A nurse saw the man on 31 December after he complained of abdominal pain and she referred him to the GP. A GP saw him on 9 January 2013, when the man said that he had suffered with lower back pain for years and had done a lot of manual work when he was young. He said that the pain was not radiating anywhere else in his body. The GP thought the man had musculoskeletal pain and prescribed naproxen, an anti-inflammatory, to help reduce muscle inflammation. He also arranged for an X-ray (which showed some degeneration in the man's spine) and for the physiotherapist to see him. The man seemed well in himself, apart from the back pain.

20. On 21 January, the man was sentenced at Croydon Crown Court to four years and four months imprisonment. The physiotherapist saw him at the end of January and noted that the X-ray showed some degeneration in his spine.

21. On 8 February, the man saw a nurse about an ongoing urine infection and told her that he had a lump in his anus. She made a routine referral for the man to see the GP. He saw the GP on 13 February and told him that he had experienced pain for the previous few weeks when he opened his bowels. He added that he had noticed some blood and thought he had lost weight despite eating normally. The GP felt a soft swelling in the man's anal passage which he thought might be an infection or a tumour. He did not mention cancer but told the man that he was concerned about the lump and made an urgent referral to hospital. The GP prescribed two antibiotics (cefalexin and metronidazole) to treat any possible infection.

22. A senior house officer at Epsom General Hospital saw the man on 28 February. The house officer wrote to High Down and said the man had a two year history of rectal pain and bleeding after defecation and reported having a tender lump around his anus for the previous two years which had been increasing in size. The house officer described him as "cachectic looking" (physical wasting due to disease – sometimes a sign of advanced cancer), although clinically well. The house officer made an urgent appointment for the man to have an examination under anaesthetic and a biopsy on 18 March.

23. On 8 March, the nurse saw the man who was in severe pain and still losing blood. The man said he could not sleep because of the pain at night and that he had to get up. She gave him some paracetamol.

24. The man had a pre-operative assessment, including an ECG and blood tests, on 12 March. On 13 and 16 March, the man dialled the telephone number of his wife in Nigeria but did not complete the calls although he had sufficient credit on his telephone account. The nurse saw the man on 16 March, who said he was still in pain and unable to sleep. He said the pain was very bad when he tried to go to the toilet or when lying down.

25. On 18 March, the man went to Epsom General Hospital. During an examination under general anaesthetic, a large rectal tumour was found and a biopsy taken. He was transferred to St Helier Hospital for a CT and MRI scan. On 20 March, the escorting staff rang the prison to report that an anaesthetist had told the man he had three tumours and that a colostomy would be performed the next day. (A colostomy is where a healthy part of the large intestine or colon is put through an incision in the abdominal wall so that faeces can leave the body.) The man was very shocked and became distressed. One of the healthcare team at the prison spoke to the lead ward nurse and asked her to speak to him to reassure him. After the colostomy, the man returned to High Down on 29 March.

26. St Helier Hospital did not send a discharge summary sheet or prescription chart so a prison nurse rang the hospital and a list of prescribed medications and discharge summary were faxed that afternoon. A prison GP prescribed the medications – a buprenorphine patch (a strong opioid painkiller) and morphine sulphate also used to relieve severe pain. The man was given a cell in the prison's inpatient unit. The discharge summary indicated that he had had a colostomy on 20 March and that the CT scan had shown a large anal mass which had spread to his liver and bones.

27. The inpatient unit manager spoke to the man on 30 March. She said he was initially upset and unhappy about some aspects of his care since getting back from hospital. The inpatient manager noted in his medical record that she had resolved the issues during the morning. One issue was the man's stoma (an artificial opening of the bowel created to collect faeces), which he wanted to have changed. The inpatient manager arranged for a nurse to check it and she considered it did not need changing. The inpatient manager decided it might be necessary for a stoma nurse to visit the man as he did not seem to know how to care for, or change, his stoma.

28. One of the prison's chaplains visited the man in the inpatient unit. The man told her he had not been able to speak to his family in Nigeria and that he wanted to speak to the Nigerian High Commission. On 1 April, a nurse noted his poor physical state and said the man had told her he had no support in this country and was only passing through when he was arrested. He was aware he was dying and wanted to go back to Nigeria. The nurse read in his record that the man had been referred to the Royal Marsden Hospital for palliative care and made a note for this to be chased up the next day. He was

given some soup and his stoma bag was changed but he said he was too tired for a shower. The head of healthcare spoke to the man about his wife. He told her that the High Commission were not in contact with his family, who were in Nigeria

29. The next day, 2 April, a doctor reviewed the man's medication and kept him on buprenorphine patches. The nurse contacted the Royal Marsden to chase up the referral. The Royal Marsden said that they had not had a referral from St Helier's and that one should be faxed urgently. The stoma team arranged to visit the man on 4 April. They agreed to chase up the referrals to St Raphael's Hospice and the Royal Marsden. Later that day, a doctor from the Royal Marsden Hospital told the inpatient manager that they would hand over the man's care to the palliative care team as no cure was available. The doctor agreed to chase up the referral from St Helier Hospital to St Raphael's Hospice.

30. Just before 8.00pm on the evening of 2 April, the man called out to staff, who found him on the floor near his toilet, went in and helped him back to his feet. The man told them he had hurt his ribs when he fell, but they could not see any signs of injury. At 3.27 in the morning, the nurse was called to see the man, who was in pain and wanted to see a doctor. The man said the stoma had not been active since the day before and he had started feeling distended two days previously. The nurse felt that he was very distended, his abdomen felt hard and his breathing was fast. The man needed help to sit up, his blood pressure was high, his pulse fast and his stoma bag empty. She gave him some oromorph (a morphine based pain killer) and called an ambulance. While waiting for the ambulance she carried out an ECG on the man which showed sinus tachycardia (an elevated heart rate above 100 beats per minute).

31. The man was taken to St Helier Hospital by ambulance at 4.10am on 3 April. A risk assessment was carried out to decide what level of staff and restraints were appropriate. This initial assessment identified his risk to the public as low, risk of hostage taking as low and his likelihood of escape (or help to escape) as low. The part of the form headed "Medical Information" was not completed. (This section asks for medical advice about any objection to the use of restraints and other medical issues that might affect the ability to escape such as mobility factors.) Despite the risk assessment and the man's state of health, the duty governor decided that two officers would escort the man and that he would be restrained by an escort chain. This means that one handcuff is attached to the prisoner's wrist and joined by a long length of chain to a handcuff on the escorting officer's wrist.

32. The ambulance arrived at hospital at 4.30am. The man's blood pressure was checked and bloods were taken for testing. A doctor saw the man and explained they would take an X-ray. He was moved to the hospital surgical assessment unit.

33. The next day two officers took over from the officers who had been with the man through the night. He was still restrained by an escort chain. The man

was quiet and slept a lot. Doctors arranged a CT scan for that afternoon. The medical team considered that the man had deteriorated significantly since his last stay a few days earlier. They decided to arrange for the man to be taken to a hospice because they assessed that further active intervention would not be possible. They told the man that if his heart stopped they would not attempt to resuscitate him. An officer wrote on the escort log that the man was incoherent and the officer was not sure if he understood what the doctors had told him. No manager from the prison visited that day.

34. On 4 April, just before 10.00am, the man told a hospital doctor that he wanted to go to Nigeria. At 10.40am, a member of the palliative care team saw him and explained he would be going to a hospice the next day, once a bed had been made ready for him. The man spent much of the day sleeping and was given pain relief by the nurses, including morphine.

35. A second risk assessment for the man's escort had been started on 3 April. The first part stated there were no security issues on the man's record. His risk to the public, of hostage taking and escape potential were assessed as "normal" and the security officer completing the form recommended double cuffing. This means that the prisoner's wrists are handcuffed in front of him and another set of handcuffs is attached to one wrist and another to an officer. The medical information section was not completed. The head of security completed the form on 4 April and decided that a two officer escort, in civilian clothes without using any restraints, was appropriate. The security manager recorded that the man was due to transfer to a hospice, that his offence was drug related and there was no information to suggest he was a risk to the public.

36. Before the escorting officers were informed of the decision, one of the officers telephoned the security manager to ask for permission to remove the man's restraints because of his medical condition and his expected time left to live. The security manager gave permission to remove the escort chain.

37. No managers from the prison visited on 4 April. The man slept through the night and was encouraged to have a drink by the nurse the next morning. He told the nurses he wanted to be deported back to Nigeria, where there was a native doctor who could cure him.

38. The man moved to St Raphael's Hospice at 10.00am on 5 April. Hospice staff asked that the man's next of kin be informed of the situation and the man gave them his wife's telephone number in Nigeria. At 3.45pm, the man spoke to his brother and his wife in Nigeria. The chaplain who was visiting him at the hospice, made an entry in the escort notes that she had also spoken to the man's wife and brother. A doctor spoke to the man's wife later that afternoon and with the assistance of a friend of his wife's in Nigeria explained her husband's prognosis. The doctor said that if the man's wife wanted to come to the UK to visit her husband, she needed to do so now. No prison managers visited on 5 April to check the escort arrangements.

39. The man had a peaceful night and during the daytime of 6 April, slept on and off and was given pain relief. A Senior Officer (SO) carried out a management check of the escort arrangements, the first recorded management check since the man went to hospital on 3 April. Hospice staff continued to care for him and gave him pain relief as required. The SO visited again at 6.40am on 7 April. At lunchtime, two nurses from High Down went to the hospice to see the man, who had slept most of the day. His breathing had also become more shallow. The Roman Catholic chaplain visited the man at 7.00pm that evening and read some psalms.

40. Two officers were the escort officers on the night of 7/8 April. The man was asleep when they arrived at 7.35pm. He remained asleep during the first part of the night. Shortly before 1.00am, the man began struggling to breathe. The nurses came in and turned him onto his side, which helped his breathing. At 2.00am, the nurses told the officers that the man had died peacefully in his sleep.

41. A family liaison officer was appointed after the man's death. Hospice staff had not contacted the man's family in Nigeria to tell them he had died so the family liaison officer first telephoned Nigeria at 11.40am on 8 April and, later that day (around 3.00pm), was able to speak to the man's brother and wife to break the news of the man's death. The family liaison officer continued efforts to speak with the man's family and another prison officer, who was from Nigeria, helped. Unfortunately, the man's family did not trust the prison and the relationship between his family and the prison broke down. The family liaison officer therefore spoke to the Nigerian High Commission whose welfare unit helped him communicate with the man's family. The prison offered either to arrange and pay for a funeral for the man in England, and then fly his ashes to Nigeria, or to pay for the cost of repatriating the man's body so that his family could arrange their own funeral in Nigeria.

42. The man's family did not tell the High Commission what they wanted to happen. After a few months the High Commission told the prison that it seemed his family could not afford to have a funeral in Nigeria. A funeral was therefore arranged at a crematorium in Surrey in June, attended by some staff from High Down.

ISSUES

Clinical review

43. The clinical reviewer said,

> "There was a relatively short period of time between diagnosis and death during which all the care the man received in hospital and at HMP High Down appears to have been appropriate to meet his health needs. The man died in St Raphael's Hospice, an outcome that could have been expected in the wider community given his age and the complexity of his disease".

44. The clinical reviewer did not identify any areas of concern in her clinical review. She considered that the man followed a similar healthcare pathway to anyone outside prison. Records indicated that the man was treated with respect and his care appeared to have been as well planned as was possible.

45. The clinical reviewer identified some examples of sensitive care shown to the man including a note that only male officers should accompany him to hospital appointments due to the nature of intimate examinations which might be required. She considered good efforts were made to give him information about his stoma including arranging a visit from a specialist nurse.

Timeliness of diagnosis.

46. There is a triage system at the prison for doctors' appointments. When the nurse saw the man on 8 February he presented with an on-going urine infection and said he had an uncomfortable lump in his anus. She made a routine referral for him to see the GP and he was seen five days later. The nurse said she might have made an urgent referral if the man had told her about other symptoms, such as bleeding from his anus. The clinical reviewer was satisfied that this was appropriate.

47. When a doctor examined the man on 13 February, he made an urgent referral for the man to be seen at the hospital as he thought the man might have a tumour. (Urgent referrals should usually be seen within two weeks). The house officer saw the man on 28 February, just on the two week timeframe. The house officer suspected the man had advanced cancer and arranged for an urgent biopsy. Cancer was confirmed after a bioposy.

48. When interviewed, the doctor expressed surprise that the man's blood tests and a liver function test taken on 23 November 2012 had come back normal as the man must have had cancer at the time. The doctor thought the results did not make sense and should not have been normal. The clinical reviewer commented that the man was a relatively young person who would have been able to replace any blood loss quickly. Any bleeding caused by the tumour would have been small in amount and would not have caused him to become anaemic, which might explain the test results.

49. We are satisfied that the man's diagnosis was made in a timely manner once he presented with his symptoms to the GP. There do not appear to have been any missed opportunities for an earlier diagnosis.

Family liaison

50. We are satisfied that the man was able to speak to his family, who were still in Nigeria. The prison added credit to the man's PIN phone account as required under Prison Service Instruction 49/2011 and he still had credit when he died. However, other than that, there is little indication of effective support for the man as a foreign national prisoner dying far from his family.

51. Prison Rule 22(1) states:

> 'Notification of illness or death
>
> '22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

52. Chapter 11 of Prison Service Instruction 64/2011 which covers the management of prisoners who are terminally ill or seriously ill states that:

> *"Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.'* [the use of italics means that this is a mandatory action for governors]

53. A hospital doctor told the man about his diagnosis on 20 March. Staff at the prison did not speak to the man until 1 April about where his family lived and they did not contact them. After this, it was the hospice staff who asked the prison to contact the man's wife and brother on 5 April, just a few days before his death. The chaplain from High Down was present at this time and helped to make the arrangements for the man and one of the doctors to speak to his family.

54. The man's condition deteriorated very quickly when he returned to the prison on 29 March after surgery, but efforts should have been made to contact his family much sooner after his diagnosis, in line with the PSI. Had this been done, the problems and distrust which occurred later might have been avoided. We make the following recommendation:

> **The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.**

Use of restraints

55. 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 decency. 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, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

56. 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. The judgement required that risks during stays in hospital needed to be assessed separately and should be reviewed regularly during a hospital stay or when circumstances change.

57. Security Group at Prison Service Headquarters issued guidance in January 2008 in response to the judgement. The guidance included advice specifically about seriously and terminally ill prisoners. It said that "separate risk assessments need to be conducted in relation to the level of restraint used for a) transportation to and from the hospital, and, b) for the prisoner's time at hospital. Any subsequent revision of the original risk assessment MUST have any medical opinion/input clearly annotated."

58. The risk assessment for the man's transportation to hospital on 3 April was authorised by the duty governor. He was assessed a being low risk of escape and to the public yet restraints were used. No medical opinion was obtained about how his health impacted on his risk of escape, as it should have been. He was restrained using an escort chain. The use of restraints was not reviewed once it became clear that the man would be remaining in hospital, as it should have been, and there were no management visits to the hospital between 3 and 5 April, which might have highlighted how poor the man's condition was. Restraints were not removed until the next day.

59. While we are pleased to note that the security manager changed the assessment and authorised the removal of the escort chain, we believe that the initial assessment did not sufficiently take the man's medical condition into account or the assessed level of risk. We make the following recommendation:

The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

RECOMMENDATIONS

1. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.

2. The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.	Accepted	There are three Family Liaison Officer at High Down who are trained in contacting family members for seriously ill prisoners. Where a prisoner is diagnosed with a terminal illness, a confidential e-mail will be sent from the Healthcare Team to Safer Custody with details of prognosis and life expectancy. Safer Custody staff will then inform the Family Liaison Officers. The Duty Governor will also be notified to ensure that any delays in contacting the prisoner's family are minimised. Where appropriate, risk assessments will include prognoses of prisoners' conditions to indicate the seriousness of illnesses.	30 September 2013	
2	The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.	Accepted	Risk assessments are completed by Security in consultation with Healthcare Managers. The Healthcare Manager will provide medical assessments for prisoners and Security will assess the risk they present prior to going on escort. The Local Security Strategy will be reviewed and amended to reflect this.	30 September 2013	