



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in March 2014,
while in the custody of HMP Holme House**

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 in March 2014, while in the custody of HMP Holme House. The man died from bronchopneumonia and skin cancer. He was 53 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by the investigator. The clinical reviewer reviewed the clinical care the man received in custody. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1999 and transferred to HMP Northumberland in 2007. He was treated for increasing skin problems during 2012 and, in April 2013, was diagnosed with cutaneous T-cell lymphoma (skin cancer). In May, the man began a course of chemotherapy at hospital which was unsuccessful. In December, he transferred to Holme House as Northumberland did not have the full time healthcare cover he then needed. He was admitted to hospital on 10 March 2014 after experiencing breathing problems, and died three days later.

I am satisfied that the man received an appropriate standard of health care at Northumberland and Holme House. However, I do not consider that the use of restraints when the man went to hospital was always justified by an appropriately considered risk assessment, a matter I have raised with both prisons before.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was sentenced to life imprisonment for murder in July 1999. In October 2007, he transferred to HMP Northumberland. The man had a history of chronic alcohol addiction and suffered from back pain, obesity and skin problems.
2. In March 2012, healthcare staff at Northumberland reviewed a wound on the man's back. A prison GP diagnosed an infection and prescribed antibiotics. Over the following months, the man's skin continued to deteriorate and he received frequent treatment. In January and February 2013, the man saw skin specialists, but they were unable to explain his condition.
3. In March 2013, a prison GP urgently referred the man to a consultant after discovering his back wound had deteriorated significantly. After tests, the man was diagnosed with a skin cancer in April. He started receiving chemotherapy treatment in May. In October, the man refused further active treatment when it became clear that chemotherapy was not working. He received palliative care at the prison and spent some time in hospital because of infections related to his condition.
4. The man moved to HMP Holme House in December after staff decided he needed 24 hour health care. He continued to receive palliative care at Holme House, and had symptom-relieving radiotherapy in February 2014.
5. On 10 March 2014, a prison GP sent the man to hospital after he experienced breathing problems. He was diagnosed with an infection and remained in hospital. His condition deteriorated significantly and he died in hospital on 13 March.
6. In light of the clinical reviewer's findings, we are satisfied that the health care the man received was equivalent to that he could have expected in the community. The use of restraints when the man went to hospital for treatment was inconsistent and not always justified by appropriately considered risk assessments. We make one recommendation.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.
9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. The investigator and the clinical reviewer interviewed staff from Holme House and Northumberland in May and July 2014. The investigator wrote to the Governors of both prisons with feedback on the preliminary findings of the investigation.
10. We informed HM Coroner for Teesside of the investigation, who provided the post-mortem report and toxicology results. The investigation was delayed slightly until we received these results. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. She did not have any specific issues for the investigation to consider.
12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
13. The man's family received a copy of the draft report. They were happy with the care that the man received.
14. The service also received a copy of the draft report. Their response to our recommendations and action plan is included at page 17 of this report.

HMP HOLME HOUSE

15. HMP Holme House is a local prison holding over 1200 men. The majority of its prisoners are remanded into custody or recently convicted by courts in the local area. Care UK provides health services at the prison. There is a 24 hour inpatient unit with 28 beds and palliative care facilities.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Holme House was in August 2013. Inspectors found that the overall standard of healthcare was good. They described palliative care at the prison as excellent, with multi-departmental care based on Macmillan Cancer Support best practice.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recent report for the year to December 2012, the IMB found a high standard of healthcare services, at least equivalent to those offered in the community. The IMB noted that a new palliative care suite was about to be opened.

Previous deaths at HMP Holme House

18. The man was the eighth prisoner to die from natural causes at Holme House since the beginning of 2013. We have made recommendations about risk assessments for the use of restraints before.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

19. The man was serving a life sentence and moved to HMP Northumberland in 2007. He was frequently treated for skin problems, including eczema, cellulitis and fungal infections. On 13 March 2012 a prison GP examined a wound on the man's back. He diagnosed an abscess and prescribed flucloxacillin (an antibiotic). The GP examined the wound again on 24 April. He noted that it had deteriorated and prescribed flucloxacillin again. A swab taken the next day revealed a bacterial infection. Over the following months, healthcare staff continued to treat the man's skin problems with antibiotics and topical medicines.
20. Another prison GP examined the man on 20 November after he complained of a swollen leg. The doctor diagnosed an infected ulcer. He prescribed flucloxacillin and planned a further review. On 27 November, a prison GP reviewed the man. The man said that the wound on his leg had been there for at least 10 years. The GP diagnosed a possible infection and referred the man to a dermatologist (skin specialist).
21. On 4 January 2013, a tissue viability nurse saw the man. They gave healthcare staff wound care advice and asked for a swab sample from the man's leg. A sample taken on 23 January revealed a bacterial infection. A tissue viability specialist saw the man on 28 January. She recorded lesions on his leg, forearm and back and recommended a specialist review.
22. A consultant dermatologist reviewed the man on 13 February, but was unable to explain his skin problems. He gave wound care advice and asked staff to review the man in three to four weeks. The dermatologist noted the outside possibility of an underlying cancer and recommended a biopsy if the man's leg wound failed to improve.
23. On 7 March, a prison GP examined the man's back wound. He was concerned that it had deteriorated significantly and urgently referred the man to a dermatologist. The man was admitted to the Royal Victoria Infirmary in Newcastle on 19 March for tests and returned to the prison on 5 April. On 9 April, the man attended an outpatient clinic at the hospital. A consultant told the man that he had skin cancer.
24. The clinical reviewer concluded that the man's referral to specialists was appropriate. He noted that the man's earlier treatments for skin conditions often appeared to be effective, which would explain why prison GPs did not refer him earlier. Specialists also initially had difficulty explaining the man's skin problems. We are satisfied that the prison doctor referred the man quickly when his skin condition deteriorated significantly and he was appropriately diagnosed.

The man's medical treatment

25. On 9 April, the consultant told healthcare staff at the prison that the man would need to return to hospital frequently for wound care and bathing. The man returned to the prison later that day. Although this is not recorded, healthcare staff told us that they had discussed the man's diagnosis and subsequent treatment with him, after he came back from hospital. The clinical reviewer was satisfied that records indicate that the man received appropriate support after he began chemotherapy.
26. On 13 May, the man went to the Freeman Hospital in Newcastle to start chemotherapy. He continued chemotherapy until September. A lymphoma nurse at the Freeman Hospital kept the prison updated on his progress. The man's medical records show that staff saw him when he returned from each appointment and provided follow up treatment as required. Nurses saw him daily on the wing where he lived and monitored his temperature to detect any sign of infection. The man was admitted to hospital quickly when staff noted symptoms of infection.
27. While at Northumberland, the man's skin continued to deteriorate and he had multiple lesions. Staff implemented a wound care plan with advice from specialists at the Royal Victoria Infirmary in Newcastle and provided skin treatments. The man attended hospital frequently for further dressing and bathing, as some of his wounds required treatment in the bath and the prison did not have suitable facilities.
28. The man completed his first cycle of chemotherapy on 5 September. After an appointment with a consultant oncologist (cancer specialist) on 11 September, the man told a nurse that the chemotherapy had not been successful, and he would require further treatment.
29. On 19 September, staff met the man to discuss his care needs and produced a palliative care plan. The lymphoma nurse and a Macmillan palliative specialist assisted with the man's care. The specialists had frequent input into discussions with healthcare staff at Northumberland about the man's care and treatment.
30. On 28 September, the man went to the Freeman Hospital with a raised temperature after reporting feeling unwell. He was diagnosed with an infection and oedema (fluid retention), and remained in hospital. Hospital staff initially planned to continue the man's chemotherapy treatment as an inpatient, but postponed this after he became too unwell.
31. Prison healthcare staff had frequent contact with the specialists and attended multidisciplinary team meetings at the hospital. On 14 October, staff responsible for the man's care met to discuss his prognosis and treatment. A consultant oncologist told the man that he was unlikely to live for more than a year. He said that any future treatment would be palliative.

32. The palliative care nurse and the clinical lead at Northumberland, discussed his prognosis with the man which he understood. The clinical lead told the man that he might require 24 hour care at a different prison in the future, which he accepted.
33. On 23 October, the man returned to the prison with a Hickman line (medication tube) in place for antibiotics. The next day, he told the clinical lead that he did not want any further treatment. The clinical lead asked him to take time to consider his decision. Healthcare staff reviewed the man daily on the wing. Care plans were set up to help monitor his pain, mobility and hygiene needs. Staff continued to provide wound care and helped the man with his medication.
34. On 5 November, the clinical lead and the palliative care nurse discussed his treatment with the man and he confirmed that he had decided not to continue chemotherapy. He said that he did not want to be resuscitated in the event of cardiac or respiratory arrest and signed an order to that effect.
35. On 13 November, the man was admitted to the Royal Victoria Infirmary for tests as his wounds were spreading and becoming infected. Specialists reviewed and adjusted his pain relief, and gave him medication for depression and nausea. On 3 December, at a multidisciplinary meeting at the hospital, the clinical lead told the man he would now require 24 hour care at HMP Holme House.
36. The man moved from hospital to the healthcare unit at Holme House on 9 December. A prison GP reviewed him on arrival and updated his prescriptions. He recorded that the man was walking with a slight waddle and was heavily bandaged, but otherwise appeared well. Later that day, he confirmed with the palliative care lead that he did not want resuscitation.
37. Healthcare staff at Holme House put care plans in place to monitor the man's daily activities and mobility, and he received daily treatment for his wounds. The man had medication reviews when he reported being in pain, and any necessary adjustments were made to his pain management.
38. The man was initially able to mobilise around the wing independently, although he used a wheelchair when he was experiencing pain. As his mobility decreased, he used a zimmer frame to help him get about. On 17 January, the man went to the North Tees and Hartlepool Hospital after he experienced breathing problems. He was treated for pneumonia and returned to Holme House on 21 January.
39. A consultant oncologist saw the man at an outpatient appointment on 30 January. The consultant oncologist gave the man a prognosis of around six months to live and offered him palliative radiotherapy. The man agreed, and in February, he received treatment at the James Cook University Hospital in Middlesbrough.

40. On the morning of 10 March, the man sat on the floor while nurses were trying to wash him. He struggled to stand up, and staff eventually used a hoist to put him in a wheelchair. A doctor reviewed the man at around 12.15pm. He was concerned that the man appeared unwell with low blood oxygen, and suspected he was suffering from an infection. The doctor gave the man oxygen treatment and the man was taken to the University Hospital of North Tees by ambulance shortly afterwards.
41. On 11 March, the hospital diagnosed an infection. A clinical manager at Holme House attended a multi-disciplinary meeting at the hospital and decided that the man would return to Holme House for end of life care after treatment for his infection. However, his condition deteriorated significantly and he remained in hospital. The man received end of life care at the hospital and died on 13 March.
42. A post-mortem revealed that the man had died from bronchopneumonia and cutaneous T-cell malignant lymphoma.
43. We agree with the clinical reviewer that the man's care and treatment in prison was equivalent to that he would have received in the community. There was good multi-disciplinary working and communication with secondary care. The man's extensive skin problems were challenging for staff, but they used specialist advice to deliver effective treatment. We are satisfied that the man received frequent support from prison healthcare staff throughout his active treatment and palliative care.

The man's location

44. Shortly after his diagnosis, the man moved to a larger cell with a hospital bed, on his wing at Northumberland. Nurses saw him daily and provided skin treatments in a room close to his cell. He frequently went to hospital as Northumberland did not have bathing facilities on the wing. The man also spent time in hospital a number of times because of infection.
45. When the man's condition deteriorated and he required more medication, healthcare staff told him that he would need to transfer to Holme House, which has 24 hour and palliative care facilities. The man was reluctant to move, but accepted that it was necessary.
46. The man lived in the healthcare unit at Holme House. His cell had a hospital bed and a hoist to help staff move him. As the man received daily wound care, industrial cleaners frequently cleaned his cell and the bathroom to reduce the risk of infection.
47. The man remained in the unit, apart from an admission to hospital in January 2014 because of an infection. He went to hospital on 10 March after another infection, where he received end of life care. We are satisfied that the man was appropriately located throughout his illness.

Restraints, security and escorts

48. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of 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.
49. The man went to hospital at least 36 times in 2013 after his diagnosis with a terminal illness. We have seen risk assessments for a number of these visits. Prison managers always directed the use of restraints, although they were removed for some treatments. When the man went to hospital for chemotherapy between May and September 2013, staff handcuffed him and used an escort chain while he was receiving treatment (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The assessments from healthcare staff did not detail his condition or treatment. They gave no medical objections to the use of restraints rather than commenting on how or whether the man's medical condition impacted on his risk of escape, as required by the 2007 High Court judgement.
50. In February 2014, the man went to hospital for radiotherapy treatment. He was not restrained for these visits. However, when he went to hospital with a serious infection on 10 March, the head of security directed the use of an escort chain. Security staff referred to the man's offences and also said he was a risk to children. The man's most recent OASys (probation risk assessment) did not indicate he was any risk to children. The medical assessment gave no objections to the use of restraints and again did not refer to the man's medical condition.
51. Around four hours after the man arrived in hospital, an escorting officer called the prison to say that the man was immobile. The head of security then reviewed the risk assessment, the clinical manager completed the medical assessment and objected to the use of restraints because of the man's extensive wounds and lack of mobility and the head of security agreed that restraints could be removed. The man was not restrained again.
52. The safer prisons and equality manager noted in an internal investigation after the man's death, that managers should always review prisoners in person

before they go to hospital so they can accurately assess their risk. However, he said that healthcare staff did not provide the duty governor with enough information about the man's medical condition. While we agree with this, we consider that prison managers would have been aware of the man's health and mobility problems.

53. The use of restraints when the man went to hospital was inconsistent. Although the prison allowed the removal of handcuffs for some treatments in 2013, the man was restrained when he received chemotherapy treatment, contrary to the 2007 High Court judgement. When the man had radiotherapy treatment in February 2014, he was unrestrained. However, less than a month later, the man was restrained when he went to hospital for the final time, even though his health and mobility had deteriorated. We welcome the fact that restraints were removed before the man died, but the initial risk assessment did not take into account his actual condition at the time or the impact of this on his risk of escape.
54. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We have made previous recommendations to Northumberland and Holme House about the inappropriate use of restraints. We consider there is a need for all those involved in making decisions to ensure that a prisoner's health and mobility are fully taken into account in risk assessments for hospital escorts and that staff follow the 2007 High Court judgment, which has recently been repeated in a National Offender Management Service (NOMS) senior leaders' bulletin. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but Heads of Healthcare also need to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

The Governor and the Head of Healthcare at Northumberland and Holme House should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

55. After the man returned to prison on 5 August 2013 after treatment for an infection, managers at Northumberland asked a trained family liaison officer, to speak to the man about contacting his family. The man told the officer that he had had no direct contact with his family for over 14 years.
56. With the man's agreement, the family liaison officer called the man's sister, his nominated next of kin, to explain his condition. She agreed to speak to the man by telephone. They spoke later that evening and the man told the family liaison officer he would like to continue contact with her. He continued to keep in touch with his sister, writing to her and speaking by telephone when he was in hospital.

57. In September, the family liaison officer asked an operational manager at Northumberland, if the man could visit his sister in Liverpool (the man's sister was unable to travel because of care commitment.) The operational manager told us that he never received a formal application from the family liaison officer. However, as an indeterminate prisoner in closed conditions, the man was not eligible for day release. The operational manager told us that Northumberland considered transferring the man to HMP Liverpool to facilitate a visit for his sister, but the man became too ill and was admitted to hospital and transferred to Holme House before this happened.
58. Two officers were family liaison officers after the man's transfer to Holme House. They frequently visited and spoke with him on the healthcare unit. The family liaison officer told us that the man continued to write to his sister.
59. On 11 March, prison managers asked another trained family liaison officer, to contact the man's sister when it was apparent he was dying. The man's sister understood he had little time left to live but was unable to visit him in hospital as she was caring for her husband. She asked the family liaison officer to pass on a supportive message to the man and they agreed that the prison would keep her updated by telephone. On 13 March, the family liaison officer telephoned the man's sister to inform her of his death. Holme House arranged and paid for the funeral in line with national guidance.
60. Although it is unfortunate that the man was unable to see his sister before he died, we are satisfied the prison kept his family informed when his condition deteriorated significantly, and that contact after he died was appropriate.

Compassionate release

61. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
62. In October 2013, consultants told the man that he had less than a year to live. The man told prison staff that he wanted to apply for early release on compassionate grounds. The clinical lead said that she spoke to the man's solicitor at his request, but could not give them any information over the telephone. She could not recall any further contact and there is no record of an application being submitted at that time.
63. In December 2013, the Parole Board decided that the man should not be released from prison. The man's solicitor told us that she had written to him after the Parole Board's decision asking if he wanted to pursue an application for release on compassionate grounds, but he did not respond.
64. At a multidisciplinary meeting at Holme House in January 2014, staff recorded that consultants had given the man a prognosis of less than a year to live. The man told staff he still wanted to pursue compassionate release. This was

not progressed at the time because his prognosis was not less than three months.

65. On 11 March, an application for early release was started after the man was admitted to hospital with an infection. A letter from the consultant oncologist said that the man's prognosis was variable but he was unlikely to live for more than six months. However, the man's condition deteriorated very quickly and he died in the early hours of 13 March before an application could be submitted. We are satisfied the prison acted appropriately and it does not appear that the man met the criteria for early release on compassionate grounds until the very end of his life.

RECOMMENDATION

The Governor and the Head of Healthcare at Northumberland and Holme House should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor and the Head of Healthcare at Northumberland and Holme House should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.</p>	Accepted	<p>HMP Northumberland's risk assessments for prisoners in hospital are dynamic and the use of restraints is reviewed as necessary, to take into account any significant changes in circumstances. Specific ongoing consideration is given to medical opinion as to the use of restraints and the prisoner's condition and treatment, with reductions in the level of restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the basis of continuous assessment of risk by the escorting staff in attendance. The risk assessments are underpinned by not only the individual's risk of escape but also their risk to the public.</p> <p>The Prisons and Probation Ombudsman (PPO) learning lessons update Fatal Incident Investigation - 5/2/13 was circulated to all Duty Governors and Custodial Managers on 18/2/14. Extracts from the update were highlighted to remind staff of their legal obligations.</p> <p>HMP Holme House's escort risk assessment form has been redesigned to ensure it highlights the present health condition and any mobility</p>	<p>Completed</p> <p>Head of Security and Operations HMP Northumberland & Head of Healthcare HMP Northumberland</p> <p>Completed</p> <p>Governor & Head of Healthcare HMP Holme House</p>	

			<p>issues of prisoners.</p> <p>The Head of Safer Prisons and Equality and Healthcare managers meet monthly to discuss the clinical Monitoring database. Prisoners with palliative care or complex case needs, and have limited mobility which is unlikely to improve, are subject to special risk assessment arrangements including:</p> <ul style="list-style-type: none">• Pre-populating escort risk assessments with medical information with specific mention of mobility issues and restraints level.• Displaying notices about their limited mobility and appropriate restraints level in the orderly room.• Displaying notices about their limited mobility and appropriate restraints level in the escort office in a prominent position		
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