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, a prisoner at HMP Sudbury, in November 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 investigation report into the death of a man, who died in November 2013, while a prisoner at HMP Sudbury. He died of bronchopneumonia caused by lung cancer. He was 75 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care the man received at HMP Sudbury. The prison co-operated fully with the investigation.

The man had been in prison for many years and was diagnosed with a number of chronic conditions, including lung disease, all of which the investigation found were managed appropriately. His health gradually deteriorated and he had a number of diagnostic tests which were inconclusive. On 15 November, a prison doctor suspected cancer and referred the man to a specialist. Just after midnight on 17 November, a night patrol officer noticed him lying on his bed in an unusual position. The officer continued with his patrol, but subsequently wondered whether the man was all right and sought help from the officer in charge of the prison. He was found to be unresponsive, but it took another 15 minutes to call an ambulance. The man was admitted to hospital for treatment, but died a few days later. A post-mortem examination found that he had undiagnosed lung cancer.

I am satisfied that the man received good care at Sudbury. His health had deteriorated slowly over the previous weeks and a prison doctor made an appropriate referral for suspected cancer. The clinical reviewer found nothing to suggest that the cancer could have been identified at an earlier stage. There was a delay in calling an ambulance and, while this did not change the outcome for the man, there is a need for the prison to ensure that staff call an ambulance immediately whenever there are serious concerns about the health of a prisoner.

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 **June 2014**

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SUMMARY

1. The man began a life imprisonment in 1965. In 2000, he was released on life licence, but was recalled to prison in October 2009 for breaching his licence conditions. He transferred to HMP Sudbury in July 2011. He had been diagnosed with several long-term medical conditions and was prescribed a strong morphine-based painkiller to control back pain he had suffered since surgery several years earlier.

2. At Sudbury, the man was diagnosed with lung disease and numerous chest infections. He developed pressure sores around the site of his previous surgery and his health slowly deteriorated.

3. Blood tests taken in November 2013 revealed that the man had abnormal liver function. A prison doctor referred him for further scans to determine if there was significant underlying disease. The scan identified little other than fluid on his lung. Nevertheless, the doctor did not think this result explained a recent deterioration in his health and, on 15 November, made an urgent referral for suspected cancer.

4. Just after midnight on 17 November, the man was found unwell in his cell at a roll check. An ambulance was called and he was admitted to hospital. He initially responded well to treatment, but he later deteriorated and died a few days later. The cause of death was established as bronchopneumonia caused by lung cancer.

5. The clinical reviewer concludes that the man's long-term conditions were managed appropriately at Sudbury. Although his death was caused by previously undiagnosed lung cancer, the clinical reviewer found that the urgent cancer referral of 15 November was timely and appropriate. When he was found unresponsive with breathing difficulties there was a delay in calling an ambulance and we make a recommendation about this.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He visited Sudbury on 29 November 2013 and spoke to the lead nurse, the prison's family liaison officer and the Chair of the Independent Monitoring Board. He went to the unit where the man had lived and spoke to a prisoner who knew him.

8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

9. The investigator and clinical reviewer together interviewed four members of staff at Sudbury on 14 January 2014 and the investigator interviewed two prisoners, including the man who responded to the notice of the investigation. He gave the Governor initial feedback and followed this up in writing.

10. We informed HM Coroner for Derby and South Derbyshire of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's brother, his nominated next of kin, to explain the investigation. He did not have any specific concerns for the investigation to cover.

12. The man's family received a copy of the draft report. They did not make any comments. The Prison Service response to the recommendation is included.

HMP SUDBURY

13. HMP Sudbury is an open prison in Derbyshire, holding over 500 men who require only minimum security. Some are life-sentenced prisoners preparing for release.

14. Health services are provided by Derbyshire Health United (DHU). The healthcare centre is open from 7.30am to 5.00pm Monday to Friday and in the morning at weekends. There are four GP clinics a week and an out of hours service is provided.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Sudbury was in October 2013. The Inspectorate found that, overall, health services were of a good standard, although most prison staff were not aware of the emergency response protocol. There was a weekly meeting for older prisoners, and individual adaptations were made for prisoners with disabilities. However, there was no paid carer scheme to help less able prisoners. The Inspectorate recommended that a designated health care lead should be appointed for older prisoners.

Independent Monitoring Board

16. Each prison 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 annual report, for the year ending May 2013, the IMB commented on a recent improvement in the standard of healthcare at Sudbury, although they found that there were a number of missed appointments. The Chair of the IMB told the investigator that most healthcare applications the IMB received were about appointments or access to medication, but these areas had recently improved considerably.

Previous deaths at HMP Sudbury

17. The man is the first prisoner at Sudbury to die since 2010. There are no similarities between the last death at Sudbury and that of his.

KEY EVENTS

18. The man was sentenced to life imprisonment in 1965. He was released on licence in 2000, but recalled to custody for breaching his licence conditions in October 2009. He transferred to HMP Sudbury on 5 July 2011.

19. During his initial health screen at Sudbury, it was recorded that the man had a catheter (to pass urine) and a stoma (to pass faeces) as a result of spinal surgery in 2008. He had constant back pain and had been prescribed fentanyl (strong pain medication). In line with the local policy at Sudbury, his pain relief was changed to MXL (another strong pain medication).

20. The man had a ground floor room at Sudbury and, shortly after he arrived, he was referred for a wheelchair assessment. He was given a wheelchair to use for longer distances around or outside the prison. Prison staff and a friend of his said that he preferred to walk when he could, sometimes assisted by his friend. He used the wheelchair mainly when he went outside the prison.

21. In May 2012, wing staff reported that the man had become more unsteady on his feet. A physiotherapist reviewed him and concluded that he was able to walk around the prison with the assistance of a walking stick. Several care plans were created to help ensure his needs were met and a nurse was designated as his lead nurse.

22. On 20 June, a prison GP examined the man, who said that he smoked and had had a cough for three months and had also lost weight. The GP referred him to the hospital for a chest X-ray. The X-ray on 12 July, found possible interstitial lung disease (inflammation or scarring of the lung). The radiologist suggested a further referral to confirm.

23. About this time, the man developed pressure sores on his back around the site of his previous surgery. He had an occupational therapy assessment and an additional care plan was written. The pressure sore was a consistent problem for him for the remainder of his life. A tissue viability nurse assessed him several times and he was given a pressure relieving mattress. The man's lead nurse told the investigator that the wound tended to improve and deteriorate in cycles and he did not always follow advice on how to manage the wound.

24. A chest specialist at the hospital examined the man on 14 November. The specialist did not agree with the previous diagnosis of interstitial lung disease and concluded that he had mild chronic obstructive pulmonary disease (COPD – lung disease including chronic bronchitis and emphysema) and mild bronchiectasis (abnormal widening of the airways of the lungs). The specialist said that no follow-up was required and told the man that the most important thing for his future health was to give up smoking. Although there is only one formal note of this in his medical record, in August 2012, we were told that he was offered help and advice about giving up smoking several times and always declined.

25. In early February 2013, the man moved to the inpatient unit at HMP Dovegate. He had been diagnosed with a chest infection and was finding it difficult to cope at Sudbury. He was not happy about the move, but he returned to Sudbury after four days, when his health had improved.

26. The man was admitted to hospital on 7 June, when he was found unwell in his room. He was diagnosed with a chest infection and prescribed antibiotics. He returned to prison later the same day. No recurrence of his symptoms was reported in the following weeks.

27. On 24 September, healthcare staff were called to assess the man as he was more unwell and had difficulty standing up. He became agitated and insisted that he did not want to go to hospital or to move to another prison (the latter option had not been suggested). Officers were asked to keep a closer eye on him overnight. The next day a prison GP reviewed the man. He asked the man to return for a blood test, but he did not attend this appointment.

28. A multidisciplinary team meeting was held on 1 October, to discuss the man's recent health. He attended the meeting, along with a prison GP, a prison nurse and the prison's Head of Residence. They noted that the man was frailer than previously and an assessment was required to determine the help and support he needed with daily living. He did not engage with the process and said it was an "agenda to ship him back to closed conditions". The man was assured that the aim of the meeting was to ensure his safety. He said that he was depressed, but did not want to take his antidepressant medication.

29. On 3 October, the man had an occupational therapy assessment. The assessor noted that he was able to walk up and down the corridor and manage his personal hygiene. She concluded that he appeared to be independent.

30. A nurse saw the man on 31 October when he said he had experienced a panic attack and felt sick. He said he had not always taken his antidepressant medication and was reminded of the importance of this. The man agreed to have the blood test that he had not attended for a month earlier. A psychiatric nurse assessed him that afternoon and advised him about managing his anxiety. The nurse had no other concerns about his mental health.

31. A GP reviewed the man on 5 November. He again said that he did not want to return to a closed prison and said that he would harm himself if a move was arranged. The GP reminded the man to take his antidepressant and suggested an increase to the dose, but he did not agree.

32. The man saw the GP again on 12 November to review the results of his blood test, which showed an abnormal liver function. The GP explained the results to him and said that they might indicate a more significant underlying disease, such as cancer. She referred the man for an urgent chest X-ray and ultrasound of the abdomen.

33. The GP spoke to the man about the possibility of a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order. (This means that in the event of a cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.) This was left as something for the man to consider in his own time.

34. The ultrasound and X-ray both took place on 13 November. The X-ray identified fluid on the man's left lung, while the ultrasound showed nothing abnormal. The GP saw the man on 15 November to review the results. She did not think that the outcome fully explained the man's poor health at the time and, after explaining this to him, she made an urgent referral to a specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The GP also prescribed a course of antibiotics.

35. The man did not attend the healthcare centre to take his pain relief on the morning of 16 November. A nurse went to see him to find out why he did not attend. He said that he had not felt able to walk to the healthcare centre so a nurse later brought his medication to him. The nurse recorded that the man was very frail, but could walk around the room slowly and was able to have a conversation with her. She told the investigator that he did not have any specific symptoms and there was nothing that gave her any cause for concern at that time. However, the nurse considered that the man was becoming frailer and might soon have difficulty coping at Sudbury. She noted that they might soon have to consider other options for his care.

36. A prisoner who helped the man with daily tasks such as collecting his meals and cleaning his room, recalled seeing him on the evening of 16 November. He told the investigator that the man looked a little worse for wear that evening when he took his meal to him.

37. An Operational Support Grade (OSG) began a roll check at around midnight on the night of 16-17 November and arrived at the man's living unit at around 12.10am. He said that he usually found the man sitting on his bed watching television. On that night, he was in an odd position with his head propped against the wall. He was lying across the bed on top of the covers.

38. The OSG completed the roll check, but was worried about what he had seen of the man. At approximately 12.25am, he contacted the night orderly officer (the officer in charge of the prison at night) for assistance.

39. The SO and an officer went to the man's room to assist the OSG. They went into his room at around 12.30am and examined him. The SO said that his breathing sounded croaky and he was unable to speak when they asked him how he was. He tried to take his pulse but could not find one.

40. The OSG had gone to some of the nearby rooms to see if any friends of the man were awake and might be able to help get a response from him. One of

his friends went to his room. He told the investigator that the man was breathing very slowly, was not responsive and appeared to be unconscious.

41. The SO radioed the prison's gate to ask them to call an emergency ambulance. The gatekeeper's log records that this call was made at 12.45am and the first paramedic response arrived at the prison at 12.50am. An ambulance arrived at 1.10am and left the prison with him at 1.30am.

42. The man was released on temporary licence to go to the hospital, accompanied by an officer. At the request of the hospital, the SO telephoned a nurse at home for information about his medical history. The SO also contacted the man's brother, his nominated next of kin, who visited him in hospital later that morning. A prison family liaison officer was appointed the same morning.

43. On the morning of 17 November the doctor treating the man telephoned the prison to ask whether he was prescribed opiate medicine, as his symptoms suggested opiate toxicity and he had responded well to two doses of naloxone, an opiate reversal agent. The nurse originally told the doctor that the man was not prescribed opiates, but this was incorrect as he had been taking an opiate based pain medication for several years and is likely to have accounted for the opiates in his system.

44. The man's health appeared to improve after his admission and initial treatment but, on 19 November, his breathing deteriorated and he was admitted to the hospital's intensive care unit and treated for pneumonia. He died several days later with his family present.

45. A post-mortem examination revealed that the man's death was due to bronchopneumonia caused by lung cancer. The pathologist noted that opiate toxicity did not contribute to his death.

46. The family liaison officer remained in contact with the man's family. The funeral took place on 5 December and the prison contributed to the costs in line with national guidance.

ISSUES

Clinical care

47. The man had various medical problems in the last years of his life, including COPD and numerous chest infections. This resulted in a gradual deterioration in his physical health. The clinical reviewer concludes that he received comprehensive health care during his time at Sudbury including appropriate management of his long-term conditions.

48. The cause of death was established at post-mortem examination as bronchopneumonia due to lung cancer. The cancer was undiagnosed at the time of the man's death. On 12 November 2013, he was referred for a chest X-ray by a GP. The results identified fluid on the lung, but nothing that indicated cancer. Nevertheless, the GP was concerned and made a two week urgent cancer referral on 15 November. He was admitted to hospital two days later and he died before the referral appointment took place. During the man's hospital admission, he was treated for pneumonia, but cancer was not identified. The clinical reviewer concludes that the referral made on 15 November was appropriate and timely.

Emergency response

49. When the OSG checked the man's room at around 12.10am on 17 November, he saw him lying in an odd position across his bed. The OSG was not immediately alarmed and completed his check of the unit. He then began to be concerned and called the duty officer around 12.25am. He did not go into his room until the SO and an officer arrived around five minutes later. The staff found the man unresponsive and breathing poorly, yet an ambulance was not called until 12.45am.

50. The OSG told us that he was not sure if anything was wrong when he first saw the man. He could not see any erratic breathing and the man did not appear to be in any difficulty, just in an odd position. However, it is apparent that he had some concerns and, rather than completing the roll check, we consider that he should have radioed for assistance immediately.

51. Prison Service Instruction 03/2013 provides the following mandatory instruction to prison staff:

> "Local procedures must ensure that staff understand they should not delay summoning emergency assistance … It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner."

52. There appears to have been ten or fifteen minutes spent in the cell with the man, including asking other prisoners to try and rouse him, before an ambulance was called. With the SO's description of his condition, we consider an ambulance should have been called immediately if he was found to be unresponsive, in line with national instructions. We note that in October

2013, HM Inspectorate of Prisons found that few staff at Sudbury were aware of the emergency response protocol. We make the following recommendation:

The Governor should ensure that all staff are aware of national guidance for calling an ambulance and understand that they should do so immediately whenever there are grave concerns about the health of a prisoner.

RECOMMENDATION

The Governor should ensure that all staff are aware of national guidance for calling an ambulance and understand that they should do so immediately whenever there are grave concerns about the health of a prisoner.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that all staff are aware of national guidance for calling an ambulance and understand that they should do so immediately whenever there are grave concerns about the health of a prisoner	Accepted	Staff information notice (SIN 074/2014) was re-issued on 19 May reminding staff that in the event of a medical emergency they should contact the communication/control room immediately using the code system - Code Blue (or Code One) and Code Red (or Code Two). The notice includes the following mandatory actions: • Upon discovery, the member of staff contacts the Communication/Control Room who then automatically calls an ambulance and awaits updates from the scene. • Where available, the Duty Nurse attends with the necessary equipment and assesses the patient. • Where no nurse over is available, other staff attend with necessary equipment. • Gate prepares to receive ambulance. • Ambulance escort staff are arranged. • Escort staff and equipment are arranged • Any further action required by the local healthcare commissioner to assist in the preservation of life SIN 074/2014 is now included in all new starters' Induction packs and will be reissued on a quarterly basis.	Completed Head of Security and Operations	