



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Northumberland, 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 in November 2013, while a prisoner at HMP Northumberland. The man died of pneumonia as a result of lung cancer. He was 66 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at HMP Northumberland. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 2004 and transferred to HMP Northumberland in January 2013. He had a number of chronic conditions, including rheumatoid arthritis for which he was under the care of a rheumatologist. On 19 June, a routine chest X-ray showed abnormalities in his right lung and a prison GP requested an urgent CT scan under the two week rule. The man was diagnosed with inoperable lung cancer on 22 July. In October, he was told the cancer had spread and he was likely to have only a matter of weeks left to live.

On 13 November, the man developed breathing problems and was admitted to hospital. He was diagnosed with pneumonia and died the next day.

I am satisfied that, overall, the man received a good standard of care at the prison. However, I do not consider the use of restraints when the man was taken to hospital was always justified by fully considered risk assessments. This is a matter I have raised with HMP Northumberland before and I expect the governor to satisfy himself that lessons are being learned.

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 convicted of sexual offences and sentenced to life imprisonment on 1 April 2004. He was sent to HMP Whatton and transferred to HMP Northumberland on the 23 January 2013.
2. At his reception health screen it was noted that the man had rheumatoid arthritis and a history of hypertension and high cholesterol. He was prescribed a number of medications.
3. The man often complained of pain to his shoulders, back, neck, hands and wrists all of which are symptomatic of rheumatoid arthritis. A prison GP saw him on 15 March and referred him for a telemedicine appointment with his consultant rheumatologist, which happened on 18 April.
4. The consultant referred the man for a routine X-ray which did not take place until 19 June. The X-ray showed abnormalities to his right lung and a prison GP made an urgent referral to a specialist and for a CT scan.
5. On 2 July, a hospital consultant informed the man that he had lung cancer. He had a course of radiotherapy at the Freeman Hospital, Newcastle upon Tyne, from 27 August to 30 August. At a follow up appointment at Wansbeck Hospital on 23 October, the man was told that the radiotherapy treatment had been unsuccessful, the cancer had spread significantly and his life expectancy was six to eight weeks. A palliative care plan was put in place the following day.
6. On 29 October, the man said he did not wish to be resuscitated in the event of cardio or respiratory arrest and signed an order to that effect. An application for release on compassionate grounds was begun, but not completed before the man died.
7. On 13 November 2013, the man was taken to hospital with breathing difficulties and found to have pneumonia (a secondary condition of his lung cancer). The man died the next day at 10.00am.
8. We are satisfied that, overall, the man received a good standard of clinical care at the prison. Although his initial diagnosis was delayed the clinical reviewer noted that his symptoms were masked by his long standing history of rheumatoid arthritis, which can have similar symptoms. However, we are not satisfied that the use of restraints when the man was taken for hospital appointments was always justified by fully considered risk assessments and make a recommendation about this.

THE INVESTIGATION PROCESS

9. The investigator issued notices informing staff and prisoners at HMP Northumberland about the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of the man's prison and prison medical records. She conducted three telephone interviews with staff in January 2014 and gave initial feedback to the Governor in writing.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
12. We informed HM Coroner for Northumberland North District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
13. One of the Ombudsman's family liaison officers contacted the man's friend, his nominated next of kin, to explain the investigation process. The man's friend did not raise any issues and told the family liaison officer that the prison and its medical services acted swiftly and with compassion. He considered that the care the man received was thoughtful and thorough.
14. The man's next of kin received a copy of the investigation draft version of the report as part of the review period. He responded to the findings of the investigation and queried an entry in the clinical reviewers report. We have sought to provide further information outside of this report in separate correspondence to the man's next of kin.
15. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, liaison with his nominated next of kin, his location, whether compassionate release was considered; and security arrangements for escorts.

HMP NORTHUMBERLAND

16. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. HMP Northumberland can accommodate more than 1,300 adult male prisoners. Care UK, a private company, provides health services at the prison.

HM Inspectorate of Prisons

17. The most recent inspection was in June 2012. The Inspectorate found that the amalgamation of the two prisons had gone well and that healthcare provision was reasonable. They found that the care of patients with lifelong conditions such as asthma, diabetes and heart disease was good.

Independent Monitoring Board

18. 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 2012 annual report, the IMB noted that prisoners had long waits in the healthcare unit before and after medical appointments.

Previous deaths at HMP Northumberland

19. There have been three deaths from natural causes at HMP Northumberland since the prison was formed in 2011. We have made recommendations about the unjustified use of restraints before.

ISSUES

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

20. The man transferred to HMP Northumberland on 23 January 2013. His reception health screen identified a medical history which included rheumatoid arthritis, hypertension and high cholesterol. He was prescribed a number of medications to treat these conditions and was under the care of a consultant rheumatologist at Airedale NHS Foundation Trust. The man smoked cigarettes and continued to smoke until his death, contrary to healthcare advice.
21. The man frequently complained of pain in his back, shoulders and hands, all of which are symptomatic of rheumatoid arthritis. He was prescribed anti-inflammatory pain relief which was reviewed regularly.
22. On 15 March, a prison GP examined the man as he complained of neck, back and shoulder pain. The man told the doctor he thought this was a flare up of his rheumatoid arthritis and requested a depo-medrone injection (a steroid injected directly into the muscle) to reduce inflammation and ease his pain. He received this on 22 March. The GP noted that the man had not been reviewed by his rheumatologist for a while and referred him for a routine telemedicine appointment. (Telemedicine is used to provide clinical health care at a distance from doctors or specialists, without the patient having to travel to visit them.)
23. The man attended the telemedicine appointment on the 18 April. The consultant revised his pain relief, recommended a change in diet and referred the man for routine X-rays of his feet, hands and chest to determine the escalation of his arthritis.
24. Routine blood tests in May showed high levels of serum C reactive protein (which indicates inflammation and can be indicative of cancer). However, the high levels were considered to be due to the man's rheumatoid arthritis.
25. The consultant's referral letter for X-rays was delayed by the hospital. Prison staff chased this up and the man eventually had his X-rays on 19 June. On 24 June, a prison GP reviewed the results of the chest X-ray which showed shadowing in the right lung. The same day, another prison GP referred the man for an urgent CT scan and for a hospital appointment under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
25. The man had the scan on 1 July at Wansbeck Hospital, Ashington. A consultant in respiratory and palliative medicine saw him on 22 July and diagnosed lung cancer. On 23 July, the clinical team manager at Northumberland spoke to the man about his diagnosis and a multidisciplinary team of both clinical and prison staff was formed to coordinate his care and treatment. A referral was also made to Macmillan cancer support services for further support and advice on how to manage his condition.

26. The records show that prison and healthcare staff made every effort to ensure that the man understood his diagnosis. A nurse told the investigator there was initially some concern about the man's understanding of his diagnosis, as he appeared to be more anxious about the pain management of his rheumatoid arthritis being overlooked. However, she was later satisfied from discussions with the man that he fully understood his prognosis and condition.
27. The clinical reviewer says that the signs and symptoms of the man's cancer were masked initially by his long standing history of rheumatoid arthritis. He points out that the man was under the care of a consultant rheumatologist and the actions taken by clinical staff in dealing with the signs and symptoms were reasonable. Once cancer was suspected, the prison GP made an appropriate urgent referral to specialists. We are satisfied that the man was appropriately diagnosed and informed of his treatment.

The man's medical treatment

28. On 31 July, the man was admitted to hospital for a lung biopsy to determine the best course of treatment. He developed a small pneumothorax (collection of air on his lung) after the procedure, but was discharged back to the prison the next day with no further complications.
29. The man attended a follow up appointment at Wansbeck Hospital on 12 August. The consultant informed him the cancer had spread throughout his chest and any treatment would not be curative. The man was offered radiotherapy to control the cancer and provide some pain relief.
30. The man began a four day course of radiotherapy on the 27 August, at the Freeman Hospital, Newcastle. His rheumatoid arthritis medication was reviewed to ensure his pain was managed effectively.
31. On 23 October, the man had a CT scan at Wansbeck Hospital. The next day, an oncologist told him that his cancer had progressed significantly and the radiotherapy had not been successful. His prognosis was six to eight weeks. The oncologist told the man he would require oxygen and prescribed medication to reduce his pain and manage the symptoms of his rheumatoid arthritis. However, the man refused to stop smoking and for health and safety reasons it was not possible to provide him with oxygen. The oncologist prescribed a steroid anti-inflammatory (dexamethasone) instead of oxygen.
32. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

33. On 25 October, an end of life care plan was discussed with the man and put in place. The care plan outlined how the man's care and pain would be managed and included regular input from a Macmillan nurse. The man was prescribed a combination of medications to manage his pain and symptoms and these were regularly reviewed.
34. On 29 October, a nurse prescriber saw the man and they discussed his wishes about resuscitation in the event of a cardiac or pulmonary arrest. The man did not wish resuscitated to be attempted and signed an order to confirm this. The order was appropriately shared with relevant officers, the healthcare team and North East Ambulance Service.
35. Records show that the man attended regular multidisciplinary meetings, to discuss his ongoing needs, care and treatment. His pain relief continued to be reviewed regularly.
36. The man developed difficulties breathing and was admitted to Wansbeck Hospital as an emergency on 13 November. He was diagnosed with pneumonia, a secondary condition to his lung cancer, and he died the next day at 10.00am.
37. The Coroner confirmed that the cause of death was complications (pneumonia) arising from terminal adenocarcinoma of the lung (lung cancer) with bilateral multiple lung metastases (secondary cancer spread from the original site) and lymphangitis (inflammation of the lymphatic vessels) affecting both lungs.
38. The clinical reviewer considered, and we agree, that the man's clinical care at the prison was of a good standard. There was an effective care plan to monitor and respond to pain and the reviewer points out that this was in line with World Health Organisation guidelines. Appropriate palliative care arrangements were made in a timely manner, which included regular input from a Macmillan nurse and involved the man. Care plans were appropriately shared and followed.

The man's location

39. The man wanted to remain in his cell on the wing and every effort was made to respect his wishes for as long as possible. However, he eventually began to have difficulties coping with his day to day care. When he was discharged from hospital on 24 October, he was moved to the health block wing for prisoners with poor mobility
40. The man was given a disabled cell with special adaptations such as a larger bed, a sit down shower, grab rails and a comfortable chair. Staff said that he appreciated the quieter environment. The move enabled the man to have access to prison carers and was closer to the prison's family liaison officer, who went to see him often. The man told staff he was happy in his new location and said he wanted to remain there for as long as possible.

41. At the beginning of November, the man's condition deteriorated and plans were made to move him to the inpatient unit at Holme House, which has 24 hour nursing care. However, on 13 November, the man became very ill and was admitted to hospital. He died in hospital the next day.
42. We agree with the clinical reviewer that the man was located appropriately and that the prison took account of his preferences.

Restraints, security and escorts

43. 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 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.
44. When the man started radiotherapy treatment at the Freeman Hospital on 27 August, the escort risk assessment indicated he was to be escorted by two prison officers and restrained using a single handcuff attached to one of the escorting officers. The man was assessed at that time as a low risk of escape and a low risk to hospital staff. No previous concerns were raised about his behaviour in prison, previous escorts or previous time spent in hospital. Healthcare staff recorded no objections to the use of restraints but did not comment on how his medical condition impacted on his risk.
45. The escort risk assessment indicated an escort chain could be used to facilitate 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) and that restraints could be removed only for medical emergencies. Security manager told the investigator the normal procedure for treatment such as X-rays, radiotherapy and scans is that restraints are removed and the area is secured. The investigator confirmed the man's restraints were removed for a scan on 27 August. However, the restraints were reapplied when the man was taken to the radiotherapy department for treatment on the same day and the escort record indicated that an escort chain was to be used during radiotherapy. The escort risk assessments for radiotherapy appointments from 28 to 30 August were not fully completed by healthcare staff and there is no mention of the man's arthritis or his reduced mobility when assessing his escape risk (which was in any event regarded as low).

46. The man was escorted to hospital on 23 October, for a further CT scan. The risk assessment remained unaltered and he was subject to a single cuff restraint and escorted by two prison officers. The risk assessment was based entirely on a security risk assessment (although this identified him as low risk most of the time) with no evidence that there was any consideration of how his health impacted on his risk of escape as the court judgement requires.
47. The man was admitted to hospital as an emergency on the morning of 13 November, the day before he died. The escort records show the man left the prison restrained by an escort chain. This was not removed until 7.45am the next day at the request of medical staff at the hospital, just a few hours before the man died.
48. The Prison Service's principal responsibility is protection of the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances which must be fully considered. We are not satisfied that restraints on each occasion outlined were justified by a fully considered risk assessment which took into account the man's risk and condition at the time. We are concerned that little heed appears to have been paid to the 2007 High Court judgement, a matter we have raised with the prison before. We make the following recommendation:

The Governor should ensure that 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 nominated next of kin

49. The man was estranged from his family and had nominated a prisoner visitor as his next of kin. An officer was appointed as the man's family liaison officer on the 16 August and remained in regular contact with him and his nominated next of kin throughout his illness
50. The family liaison officer informed the man's next of kin of his death the same day, and the prison contributed to the cost of the funeral in line with national policy.
51. We are satisfied that the prison appointed a family liaison officer when the man became seriously ill and that he, and his nominated next of kin, were well informed and supported.

Compassionate release

52. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A

clear medical opinion of life expectancy is required. The criteria for early release indeterminate prisoners are set out in Prison Service Order (PSO) 4700. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

53. On 24 October, when the man was informed his life expectancy would be six to eight weeks, he asked to be considered for release on compassionate grounds.
54. The prison started the application process on 30 October and requested information from healthcare staff on 31 October. This information was initially delayed as a prison GP asked to see the man about the application, but the man refused to attend. The appointment went ahead on 8 November, but the application was not completed before the man died.
55. Appropriate release arrangements had not been organised for the man, and it therefore seems unlikely that a compassionate release application would have been successful. However, we are satisfied that the prison began the process as soon as the man indicated that he wished to be considered for compassionate release.

RECOMMENDATION

The Governor should ensure that 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 <u>function responsible</u>
1	<p>The Director should ensure that 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>	<p>Accepted</p>	<p>Further to NOMS guidance issued in 2008 following the <i>Graham</i> judgement, subsequent guidance was issued to all Governors and Directors on the use of restraints, most recently in January 2014.</p> <p>In line with the national guidance, healthcare staff now provide more detailed information about a prisoner’s mobility and other relevant health factors when risk assessments are completed prior to them being escorted to outside hospital. The risk assessment documentation also states explicitly that escorting staff must contact the prison if there is any deterioration in the prisoner’s health while they are in hospital.</p> <p>Any decisions to increase or reduce the level of restraints must be fully accounted for and clearly documented to substantiate decision making. These requirements have been repeated to relevant staff and managers by the Director who is confident that decisions taken now are much better informed, reflecting each prisoner’s health and mobility.</p>	<p>Complete and ongoing</p> <p>Head of Security and Operations and all Operational Managers that authorise escort/bed watch risk assessments</p>