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 in June 2014, while in the custody of HMP Hewell

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 from lung cancer in June 2014, while in the custody of HMP Hewell. He was 61 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Hewell was undertaken. The prison cooperated fully with the investigation.

The man was diagnosed with lung cancer on 11 March 2014. On 17 March 2014, he was sentenced to 34 weeks in prison and was sent to HMP Hewell. On 10 April, a hospital consultant told him that his condition was incurable and he would need further tests to determine if palliative radiotherapy was appropriate.

On 16 April, the prison transferred the man to HMP Stafford in error and he was returned to Hewell on 29 April. This disrupted his treatment and led to him missing a lung biopsy on 1 May, which was then rearranged for 8 May. The results were inconclusive and doctors planned a liver biopsy. However, his health deteriorated significantly and, on 30 May, the hospital admitted him for treatment. A specialist told him that he had just a matter of weeks to live. On 6 June, he moved to a hospice, where he died several days later.

I agree with the clinical reviewer that the standard of care the man received at Hewell was not equivalent to that he could have expected to receive in the community. He appears to have received very little medical or nursing attention after he returned from Stafford. He had no care plan, no one reviewed his symptoms and he did not have a GP appointment in his last month at Hewell. I am also concerned that the use of restraints when he went to hospital was not always justified by fully considered risk assessments.

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 **November 2014**

CONTENTS

SUMMARY

1. On 17 March 2014, the man was sentenced to 34 weeks in prison for theft, failing to surrender to custody and failing to comply with the conditions of the sex offender register. He was also given a restraining order not to contact his sister. He was sent to HMP Hewell the same day.

2. On 18 March, the man told prison healthcare staff that he had been diagnosed with cancer the week before. A prison GP urgently requested his community medical records. On 20 March, the prison obtained confirmation that he had advanced lung cancer with likely liver metastases.

3. On 10 April, a specialist at the hospital told the man that his condition was not curable and that he would need a lung biopsy to determine if palliative radiotherapy was appropriate.

4. On 16 April, the man was transferred to HMP Stafford in error. He was returned to Hewell on 29 April, but missed a scheduled lung biopsy on 1 May, which the hospital rearranged for 8 May. The results were inconclusive and the specialist referred him for a liver biopsy to help plan his future treatment.

5. The man went to the hospital on 30 May for the liver biopsy, but was too unwell. The hospital admitted him with severe anaemia and he had a blood transfusion. The specialist told him that his cancer was very advanced and he had only a matter of weeks to live. He moved to a hospice on 6 June where he died several days later.

6. The clinical reviewer was concerned that the man did not have a care plan at the prison with a named doctor to oversee his care. He had little contact with the prison GP and no one prescribed his medication in a planned way or regularly reviewed it. The clinical reviewer concluded that the standard of healthcare he received at Hewell was not equivalent to that he could have expected to receive in the community.

7. We are also concerned that risk assessments for the use of restraints when the man went to hospital were inconsistent and did not fully take into account his actual condition at the time and the impact on his risk of escape.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

10. The investigator obtained copies of the man's prison medical records and extracts from his prison record. She interviewed three members of staff at HMP Hewell on 11 August 2014, and gave the Governor initial feedback about the preliminary findings of the investigation.

11. We informed HM Coroner for Birmingham and Solihull of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's nephew to explain the investigation. He did not have any specific issues for the investigation to consider.

13. 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.

14. The man's family were informed the draft report was available, but did not raise any issues.

HMP HEWELL

15. HMP Hewell comprises two separate sites – a closed local prison (formerly HMP Blakenhurst) and an open prison known as The Grange Resettlement Unit (formerly Hewell Grange), The closed site, where the man lived, takes prisoners from courts in the West Midlands, Warwickshire and Worcestershire and holds up to 1074 men in six houseblocks. Worcestershire Health and Care NHS Trust provides 24 hour health care.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Hewell was in November 2012. The Inspectorate found that there was a good staff skills mix in the health care unit, but there were staff vacancies. Prisoners they surveyed were generally dissatisfied with the quality of health care services as well as their access to them. Inspectors found the range and quality of most services were good, except that prisoners waited too long to see a GP. All prisoners had adequate health screens when they arrived. Pharmacy services were satisfactory. Inspectors noted that there were procedures for the care of terminally ill prisoners.

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 recently published report for the year to November 2013, the IMB noted that there had been some progress in relation to some of the deficiencies in healthcare identified by the Inspectorate at the 2012 inspection including dealing with staff vacancies, which it hoped, would help resolve problems experienced throughout the year, with GP waiting times.

Previous deaths at HMP Hewell

17. The man was the third prisoner to die from natural causes at Hewell since the start of 2012. There were no significant similarities with issues identified in previous cases.

ISSUES

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

18. On 17 March 2014, the man arrived at Hewell after receiving a thirty-four month prison sentence for theft, failing to surrender to custody and failure to comply with the sex offender register. A restraining order was also made preventing him from contacting his sister. He had a number of health problems including asthma, chronic obstructive pulmonary disease, chronic neck pain and alcoholism.

19. On 18 March at an initial health screen, the man told a prison GP that he had lung cancer. The GP urgently requested his community medical records. On 20 March, the prison received a discharge summary from a hospital in Birmingham which confirmed a diagnosis of lung cancer, which had possibly spread to his liver.

20. On 20 March, a prison GP asked administrative staff to contact the hospital for follow up appointments with the oncologist. There is nothing in the medical records to indicate this was done. On 1 April, the GP chased this up. The man had missed a follow up appointment in March, which was rearranged for 10 April.

21. On 10 April, the man attended another hospital. The oncologist told him that the lung cancer had progressed and his condition was now terminal. The oncologist amended his medication and arranged a multidisciplinary meeting at the hospital the next day to discuss his ongoing care.

22. Doctors had informed the man of his diagnosis before he arrived at Hewell. We are satisfied that healthcare staff acted quickly to confirm his diagnosis with the hospital. A hospital doctor told him on 10 April that his condition was terminal. However, there is nothing in his records to show that healthcare staff, or other staff at the prison, talked to him about his diagnosis after he received the news of his terminal illness, or actively supported him. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that prisoners with terminal illnesses receive appropriate support after their diagnosis and record it properly.

The man's medical treatment

23. The multidisciplinary meeting on 11 April decided that the man needed a lung biopsy to determine if symptom-relieving palliative radiotherapy was appropriate. On 15 April, the hospital informed the prison that they would arrange a biopsy within fourteen days; he was on a 'medical hold' to prevent him being transferred to another prison so that his care would not be disrupted. However, on 16 April, he was transferred to HMP Stafford. The Head of Healthcare at Hewell told us that the transfer was authorised in error. Stafford pointed out the mistake and he returned to Hewell on 29 April.

24. Discussions with a custodial manager in the prison's offender management unit, suggested that the system to enforce medical holds was haphazard, as healthcare staff used the electronic medical record system, SystmOne, to note a medical hold rather than placing alerts in the prison's electronic records, PNOMIS. When the man had been placed on the list for transfer, a nurse would have had to agree that he was fit to transfer, but no one had noticed his ongoing medical treatment.

25. On 1 May, the hospital had scheduled a lung biopsy which the man missed, apparently because his move to Stafford had disrupted his ongoing care. After his transfer, healthcare staff at Hewell had not been in touch with the hospital for follow up appointments and had not checked again immediately, when he returned from Stafford. We make the following recommendation:

The Governor and Head of Healthcare should ensure there is an effective 'medical hold' system to prevent prisoners with serious illnesses having their care disrupted by transfers to other prisons.

26. The man's rearranged lung biopsy took place on 8 May. On 20 May, a nurse at the hospital told healthcare staff that the results of the lung biopsy were inconclusive and arranged a liver biopsy for 30 May to help inform further treatment options. When he went for the biopsy, the hospital cancelled it as he was too unwell and admitted him as an inpatient. The oncologist told him he was likely to live for just a matter of weeks or months at most. On 2 June, he had a blood transfusion for severe anaemia.

27. On 4 June, palliative care nurses visited the man at the hospital to discuss his prognosis and end of life care. He said he would like to go to a hospice and, on 6 June, he was transferred. He received end of life care at the hospice, and died several days later.

28. After he returned from Stafford on 29 April, the man received very little medical or nursing attention. A prison GP saw him on 29 May, when he was visiting his cellmate. He noted that he had asked for a GP appointment, but a GP did not formally review him at any time after he had returned from Stafford.

29. We agree with the clinical reviewer that the main omission in the man's care was the lack of a care plan which would normally include a named doctor in control of the patient's care. Care plans ensure that the patient's symptoms and pain are managed appropriately and this did not appear to happen in his case. We agree with the clinical reviewer that his clinical care fell below what would have been available to him in the community.

The Head of Healthcare should ensure that a lead doctor is appointed as soon as a prisoner is diagnosed with a terminal illness, and that a care plan is initiated covering all aspects of the prisoner's treatment and care.

The man's location

30. The man lived on a wing reserved for elderly prisoners at Hewell, in a double cell on the ground floor. On 1 April, a GP noted that he used a walking stick to get about. He had asked for a single cell because his persistent cough was keeping his cellmate awake. The GP agreed to support his request. The prison put him on a waiting list. All the singles cells were on an upper landing and, as his mobility decreased, staff were concerned that he would not be able to manage the stairs. He was admitted to hospital on 30 May, before a cell became available.

31. On 3 June, after a multidisciplinary team meeting at the hospital to discuss end of life care, the Head of Healthcare began to look at end of life options and contacted HMP Whatton to discuss the possibility of him moving to their palliative care suite. Whatton would not accept him, as they reserved their facility for prisoners already at Whatton.

32. On 4 June, the man told palliative care nurses that he would prefer to go to a hospice for end of life care. He stayed in hospital until a hospice bed became available. On 6 June, he moved to a hospice and stayed there till he died.

33. We are satisfied that the man had appropriate accommodation in the prison which met his needs. Healthcare staff and specialists agreed to transfer him to the hospice when his symptoms suggested that he required end of life care.

Restraints, security and escorts

34. 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 regarding 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.

35. On 10 April, the man went to hospital and learnt that his cancer had spread extensively. At the time, a consultant noted that he would not be able to walk more than three hundred yards. A month later, on 8 May 2014, he attended another outpatient appointment for a lung biopsy. For both appointments, two officers escorted him and used single handcuffs to restrain him. The escort risk assessment noted that 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.) The assessments noted that he was a medium risk to the public and a low risk of escape. There was no healthcare input into either risk assessment to say how his condition affected his risk of escape.

36. On 30 May, when the man went to hospital for a liver biopsy the risk assessment noted he was a medium risk to the public. As with the previous risk assessments, there was no healthcare assessment of how his illness impacted on his ability to escape. He was accompanied by two officers and was double cuffed. Hospital staff assessed him as being too ill for treatment and admitted him to hospital. Officers used an escort chain to restrain him and there is no evidence from the records that this was removed when he had a blood transfusion. From 4 June, managers agreed to remove all restraints and reduced the escort to one officer.

37. We are concerned to note that officers used double cuffs on 30 May. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner, like the man, the Prison Service requires that reasons should be recorded in writing. This was not done. The acting Head of Operations told us that their use had been linked to an escape alert. However, the escape alert information was historic and she could not explain why the level of restraints had increased from previously. There is no evidence to support this decision and we can see no reason why it would be justified.

38. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which staff should fully consider and balance against the security risks. We are pleased to note that the prison did not use restraints towards the end of the man's life. However, we are not satisfied that the earlier use of restraints was justified by fully considered risk assessments that took into account his risk and condition at the time. We are concerned that the prison appears to have taken little account of the 2007 High Court judgement, a matter we have raised with Hewell 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 family

39. On 31 May, when the man was admitted to hospital, the Head of Operations discussed with him whether he wanted his family informed. He had nominated his brother-in-law as his next of kin as there was a restraining order preventing him contacting his sister. He did not want anyone to contact his family as he did not want them to visit him while he was chained to an

officer. Eventually he agreed that the prison should inform his family of his illness. Family members visited him in at the hospice on 6 June.

40. We are satisfied that the prison helped the man establish contact with his family and inform them of his illness. However, although there were also other complicating circumstances, the fact that he was reluctant to allow his family to visit him while prison officers were using an escort chain to restrain him, underlines the need to ensure that decisions about the use of restraints for terminally ill prisoners are fully justified.

41. The funeral took place on 4 July. In line with national guidance, the prison contributed to the funeral costs.

Compassionate release

42. 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.

43. On 30 May, when the consultant told the man that his life expectancy was very limited, managers at Hewell considered releasing him on temporary licence (ROTL) but the Governor decided that this was not appropriate because of the nature and circumstances of his offence and his risks to others.

44. On 12 June, a GP applied for early release on compassionate grounds on behalf of the man. Sadly, he died before the application was progressed.

45. We are satisfied that the prison appropriately considered the possibility of release on temporary licence and release on compassionate grounds.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that prisoners with terminal illnesses receive appropriate support after their diagnosis and record it properly.

2. The Governor and Head of Healthcare should ensure there is an effective 'medical hold' system to prevent prisoners with serious illnesses having their care disrupted by transfers to other prisons.

3. The Head of Healthcare should ensure that a lead doctor is appointed as soon as a prisoner is diagnosed with a terminal illness, and that a care plan is initiated covering all aspects of the prisoner's treatment and care.

4. 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 function responsible
1	The Governor and Head of Healthcare should ensure that prisoners with terminal illnesses receive appropriate support after their diagnosis and record it properly.	Accepted	The care of all men with a terminal illness are discussed by the Primary Care Multi Disciplinary Team, attended by GPs, lead nurse for primary care, Pharmacist and deputy Head of Health Care once a week and the patient's record on SystmOne is documented and updated. A named lead professional then ensures follow up and appropriate care is given.	Head of Healthcare Completed
2	The Governor and Head of Healthcare should ensure there is an effective 'medical hold' system to prevent prisoners with serious illnesses having their care disrupted by transfers to other prisons.	Accepted	There is a process for medical hold on SystmOne records and all staff have been reminded to check for this before fitting a patient for transfer.	Head of Healthcare Completed
3	The Head of Healthcare should ensure that a lead doctor is appointed as soon as a prisoner is diagnosed with a terminal illness, and that a care plan is initiated covering all aspects of the prisoner's treatment and care.	Accepted	GP's are now appointed once a patient has been identified and care plans are added to the SystmOne records. All staff have been reminded to ensure that when they see a patient who has any chronic or life threatening disease, appropriate care plans are in place on SystmOne.	Head of Healthcare Completed

4	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.	Accepted	Hospital/bedwatch risk assessments to be updated to include guidance so that the decision maker fully considers the health of the prisoner, current risk of escape as well as public protection in terms of re-offending particularly in relation to harm to others.	Head of Safety 30 November 2014