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 November 2014, while in the custody of HMP Lewes**

## *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 of liver cancer and other liver disorders on 12 November 2014, while a prisoner at HMP Lewes. He was 56 years old. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation. A clinical reviewer reviewed the clinical care the man received at HMP Lewes. The prison cooperated fully with the investigation.

The man was sentenced to 26 weeks imprisonment on 15 September 2014 and sent to Lewes. He had hepatitis C and received treatment at the prison for long-standing drug and alcohol problems. Four days after he arrived, he reported that he was coughing up blood and feeling generally unwell. A prison GP noted that his liver was enlarged and referred him for tests, which indicated liver cancer and cirrhosis. The man's health declined rapidly and he became jaundiced and lethargic. He was emaciated and weighed only seven and a half stone. On 7 November, he was admitted to hospital where he remained until he died, five days later.

I am satisfied that the man received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community. However, I am concerned that, on occasions, he was restrained with handcuffs, without a fully considered risk assessment that adequately took into account his health and mobility. I am also concerned that the prison did not contact the man's next of kin when he was seriously ill, as Prison Rules require, but waited until after his death.

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** **May 2015**

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## SUMMARY

1. The man received a 26-week prison sentence for breach of licence after two offences of shoplifting and arrived at Lewes on 15 September 2014. He had been in prison many times.

2. At an initial health screen, a nurse recorded that the man was positive for hepatitis C and showed signs of withdrawal from drugs and alcohol. A prison GP detected an abdominal murmur and referred him for an ultrasound scan. After two days in the first night reception centre, he went to the prison's drug treatment wing.

3. On 19 September, the man complained of pain in his shoulder, coughing up blood and feeling generally unwell. A prison GP noted that he had an enlarged liver and referred him to hospital for an X-ray. The medical section of the risk assessment form for his appointment stated that he was unable to walk long distances and might need a wheelchair at the hospital. In spite of his poor mobility, officers took him to the appointment restrained by two sets of handcuffs. Another GP reviewed recent blood tests, which showed abnormalities. The GP thought it likely that he had liver cancer.

4. The man continued to feel unwell and suffered from vomiting, a lack of appetite and abdominal pain. In mid-October, an ultrasound scan of his abdomen indicated signs of liver failure. Officers used a single set of handcuffs to restrain him when they took him for his appointment and an escort chain during treatment.

5. On 21 October, a prison GP referred the man urgently to the medical gastroenterology team at an outside hospital. The hospital did not schedule an appointment before the man's final admission to hospital.

6. On 7 November, staff were concerned about the man's condition. He was emaciated, jaundiced, dehydrated and suffering from abdominal pain. A GP referred him to hospital and he was taken to hospital restrained by handcuffs. He was admitted to hospital as an inpatient and officers removed the handcuffs shortly afterwards. They did not use restraints again.

7. The man's condition continued to deteriorate in hospital and he refused medical intervention. Although he was critically ill, the prison did not inform his next of kin. He died in hospital.

8. We are satisfied that the man received an appropriate standard of healthcare at Lewes. However, the use of restraints when he went to hospital for treatment was inconsistent and not always justified by appropriately considered risk assessments. The prison should have informed his next of kin that he was seriously ill. We make two recommendations.

## THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed five members of staff at Lewes on 8 December and a further member of staff on 15 December, by telephone.

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

12. We informed HM Coroner for East Sussex of the investigation, who provided the post-mortem report. 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, and two members of his family members to explain the investigation. The man's next of kin wanted to know why the prison had not informed her that he was terminally ill or that he had been admitted to hospital on 7 November.

14. The draft report was issued for consultation with the prison service. They pointed out some factual inaccuracies. This report has been amended accordingly. The action plan has been added to the end of this report.

15. The man's friend received a copy of the draft report. She did not make any comments.

## HMP Lewes

16. HMP Lewes is a local prison serving the courts of East and West Sussex and with a current capacity of 722 remanded men. The Sussex Partnership NHS Foundation Trust provides general health services and Custodial Medical Services Limited provides the GP service. There is an inpatient unit with a current capacity of 12 beds.

## HM Inspectorate of Prisons

17. The most recent inspection of Lewes was in November 2012. The Inspectorate found healthcare was reasonable. External hospital appointments were rarely cancelled. There was good access to, and links with, a nearby hospital for general issues and X-rays.

## Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its most recently published report for the year to 31 January 2014, the IMB noted that the healthcare team cared for prisoners with chronic and life limiting conditions with respect and understanding.

## Previous deaths at HMP Lewes

19. This man's death is the fourth of five, from natural causes, at the prison since 2010.

20. We have previously recommended that risk assessments for prisoners going to hospital fully take into account their individual circumstances and are based on the actual risk the prisoner presents.

## KEY EVENTS

21. The man received a 26-week prison sentence for breach of licence, after two offences of shoplifting. He arrived at Lewes on 15 September 2014 and was due to be released on 14 December 2014. He had served many previous prison sentences, most recently at HMP Highdown in August 2014. He was homeless when he was sent to HMP Lewes.

22. At an initial health screen, the man said that he smoked heroin daily, and took diazepam for anxiety, diconal, a painkiller, and methadone, used to treat heroin addiction. He had symptoms of withdrawal from drugs. He had hepatitis C and had been a heavy drinker for many years. A prison GP saw him the same day and prescribed methadone. She detected a murmur in his abdominal area and asked for an ultrasound scan to assess him for abdominal aortic aneurysm (swelling of the main artery supplying the lower limbs).

23. A drug treatment specialist reviewed the man on 16 September and noted he reported symptoms of opiate withdrawal, including stomach cramps, nausea and insomnia. He received his methadone as prescribed. He spent two days in the prison's first night and reception centre and then moved to K Wing, the drug stabilisation unit.

24. On 19 September, the man told the drug treatment specialist that he had a pain in his shoulder, blood in his sputum when he coughed, and that he felt generally unwell. She referred him to a GP.

25. On 22 September, a prison GP examined the man and noted that he was underweight, had been coughing up blood and had an enlarged liver. He referred him for a chest X-ray and blood tests at outside hospital.

26. A prison GP examined the man on 24 September and diagnosed a chest infection. She reviewed the results of blood tests, which showed his Alpha Beta protein level was abnormally high. He noted that the man almost certainly had a malignancy (cancerous tumour) and that the previously requested scan of his abdomen should include his liver. Other blood tests revealed very abnormal liver function, as well as a macroscopic anaemia (meaning the red cells were larger than normal). His kidney blood tests were normal. The GP prescribed a food supplement to help him gain weight.

27. The man went to an outside hospital for a chest X-ray on 29 September. On 25 September, a nurse had completed the medical information section of a risk assessment to determine the level of security required. He noted that the man was unable to walk long distances and might need to use a wheelchair at the hospital. There was no medical objection to the use of restraints. The security section of the assessment, dated 26 September, noted he did not have a security classification, but met the current category C criteria and that he was low risk of escape and to the public. On 27 September, an operational manager concluded that the man should be double cuffed with a two-officer escort. 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.

28. After the man's chest X-ray, the consultant radiologist noted that his heart was normal and his lungs were clear.

29. On 5 October, the man told a nurse that he had vomited and felt unwell. A prison GP saw him the next day and told him that his blood results indicated a likely diagnosis of liver cancer. The GP increased his methadone dose.

30. On 15 October, the man went to outside hospital for the ultrasound scan of his abdomen. His escort risk assessment again indicated he was low risk. Some contributions to the risk assessment were made some days before. A nurse, on 2 October, did not object to the use of restraints and the section about medical conditions noted "N/A". The security department considered he was category C, with no intelligence to suggest a raised risk. A single set of handcuffs were used to restrain him and it was noted that an escort chain could be used during treatment. (An escort chain has a handcuff at each end, one to attach to an officer and the other to the prisoner.)

31. The ultrasound scan showed an enlarged liver, an enlarged spleen and some abdominal and pelvic ascites fluid (fluid due to liver failure) within his abdomen cavity. These were all indicative of liver cirrhosis. The hospital advised Lewes' healthcare department to refer the man for further investigation.

32. On 21 October, a prison GP reviewed the man and noted he had an enlarged spleen, as well as portal hypertension (high blood pressure changes within the circulation of the liver and biliary system due to a diseased liver). She prescribed him propranolol to try to reduce the portal hypertension and said she would discuss his condition with the liver team at outside hospital that day. The same day, healthcare staff posted and faxed an urgent referral to the medical gastroenterology team at outside hospital. In her referral letter, the GP requested an early, urgent assessment of the man. She noted that she was concerned that he might be suffering liver failure.

33. On 23 October, the man told a nurse that he was in pain, extremely lethargic, his legs were weak and he had abdominal discomfort. Later that day, a prison GP examined him and noted his abdomen was firm with excessive fluid. She stopped the propranolol and noted that if he did not improve, he should move to the prison's inpatient unit. The next day, a bed became available, but he did not want to move.

34. On 24 October, a drug treatment specialist noted that the man continued to feel lethargic and nauseous. His blood pressure, pulse and weight were stable. She offered to move him to the inpatient unit, but again he said he did not want to move. The next day, he still did not want to move and said he was adequately supported on K Wing.

35. On 24 October, he asked for pain relief for abdominal discomfort. A nurse did not notice any change in his condition and suspected he might have been trying to obtain drugs for his friends. He did not give him any additional pain relief, but commented the methadone should have some pain-relieving effect. A prison GP increased his methadone prescription that day and noted that he was jaundiced.

36. On 4 November, healthcare staff chased up the man's earlier referral to the hospital gastroenterology department. Hospital staff confirmed that the appointment was on their system but a date had not yet been scheduled.

37. On 6 November, a healthcare manager recorded that the man had fluid swelling under the skin of his lower limbs, shortness of breath and a swollen lower abdomen. He noted that he would arrange an appointment for the GP to review the man the next day.

38. On 7 November, the man's condition deteriorated. A doctor referred him to hospital and, at 11.45am, he went to outside hospital by emergency ambulance. The referral letter stated he was dizzy, unable to stand, unsteady on his feet and had abdominal pain. His observations were stable but he was emaciated, jaundiced and dehydrated. His abdomen was distended and tender. The matron at Lewes, who saw the man before he left the prison, said that he weighed 48kg (7.5 stone) and needed help to be able to walk.

39. The man's escort risk assessment judged him low risk to the public and of escape. The healthcare entry noted that he had a terminal illness but gave no further information. He was handcuffed to one of the two escort officers. He arrived at the hospital at 12.13pm and the escort officers removed the handcuffs, at 1.08pm, for treatment. At 1.30pm, one of the escort officers spoke to the operational manager at the prison who authorised that the man could remain uncuffed while he received treatment. The next day, the escort log noted that a manager had agreed that he could remain uncuffed until a further risk assessment. There is no record of a further risk assessment, but it does not appear that officers used restraints again.

40. The man's condition continued to decline, but he refused medical interventions. He remained in hospital and the prison obtained updates about his condition. In a discussion with hospital medical staff on 10 November, a prison GP made it clear that the man needed to be referred to a hospice, as Lewes did not have the capability to manage his end of life care. He asked that the man's consultant should liaise with the prison's matron and the man's probation officer to provide a letter in support of an application for early release on compassionate grounds. The man died in hospital at 6.44am shortly thereafter, before an application was submitted.

**Liaison with the man's next of kin**

41. On 11 November, the prison appointed a family liaison officer. The family liaison log shows that the prison was aware of the seriousness of the man's condition and poor prognosis at the time. Despite this, no one contacted his

friend, who was his nominated next of kin. After he died, the deputy family liaison officer informed the man's next of kin of his death at 10.30am that day, in person.

42. According to the family liaison officer's log, at the time of the man's death and for several days afterwards, the prison did not have any contact details for his family. His next of kin then gave them the man's sister's address. The prison contacted police to confirm the address and asked them to let his sister know that he had died. The police informed his sister on 17 November. In line with national guidance, the prison contributed to the costs of the funeral.

**Support for prisoners and staff**

43. A Governor's notice informed prisoners and staff of the man's death and offered support. Staff checked prisoners considered at risk of suicide or self-harm in case they had been adversely affected by the news of the man's death.

**Post-mortem**

44. A post-mortem examination concluded that the man died as a result of disseminated hepatocellular carcinoma with liver failure (widespread cancer of the liver causing the liver function to fail) and chronic hepatitis C virus infection and alcoholic liver disease with cirrhosis (irrecoverable scarring of the liver tissue contributing to the liver's inability to function).

## ISSUES

### Clinical care

45. The clinical reviewer noted that there were two delays in the provision of external medical treatment for the man. Neither were the responsibility of the prison. The first, for his chest X-ray, was due to the lack of available appointments at the hospital. The second delay occurred when the medical gastroenterology department at an outside hospital did not schedule him an appointment for assessment. The man's treatment in hospital is beyond the remit of this investigation. However, the clinical reviewer considered these delays would not have affected the outcome or the speed of the deterioration in his health.

46. The clinical reviewer concluded that the man's clinical care at the prison was the equivalent of that expected in the community. We agree.

### Restraints, security and escorts

47. 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. The level of restraints 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

48. Although the man had not been formally categorised, he was assessed as category C. The risk assessment for his hospital appointment on 29 September indicated that he could not walk long distances and might need a wheelchair. He was regarded as low risk of escape and low risk to the public. Despite this, officers used double handcuffs to restrain him. Double handcuffs are usually used for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner, the Prison Service requires that reasons should be recorded in writing. This was not done and the use of double handcuffs could not have been justified.

49. For his hospital appointment on 15 October, single handcuffs were used. When he went to hospital on 7 November, a nurse stated that the man had a terminal illness and as with all the other risk assessments, he was regarded as low risk. Despite his very poor health at the time, restraints were used. We are pleased to note that they were removed later that day and not used again.

50. When interviewed, healthcare staff said that the decision whether to restrain a prisoner was the responsibility of security staff at the prison. They considered

that only where a medical condition would mean that a restraint could not be put in place, such as a broken arm, would healthcare highlight this. This is not the test the High Court judgment requires. While the final decision is a matter for a senior operational manager, healthcare staff should comment on how the prisoner's health condition and mobility might impact on his risk of escape, to inform that decision. We also note that some of the information provided was out of date and did not reflect the man's condition at the time. His health deteriorated rapidly while he was at Lewes, but this was not reflected in each of the risk assessments.

51. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that this was done in line with the 2007 High Court judgement. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly. However, the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities, and have appropriate and considered input into the risk assessment process. We make the following recommendation:

**The Governor and the Head of Healthcare 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**

52. The man's next of kin was a friend, whose contact details were listed on his record. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill.

53. The prison did not inform the man's next of kin when he was diagnosed with a terminal illness or when he went to hospital on 7 November. The explanation given was that his appointment on 7 November had been regarded as routine and he was expected to return to the prison. However, doctors had already identified he was terminally ill and he was admitted to hospital that day because his condition was serious. We consider the prison should have contacted his next of kin at that stage. This would have enabled his friend the opportunity to visit and spend time with him before his death. We make the following recommendation:

**The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible of their illness.**

## RECOMMENDATIONS

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

2. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible of their illness.

## Action Plan

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and Function Responsible |
|---|---|---|---|---|
| 1 | The Governor and Head of Healthcare at Lewes should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, and based on the actual risk the prisoner presents at the time. | Accepted | The legal position will be widely publicised amongst Duty Governors, Orderly Officers and Healthcare Managers. Alongside this, a review of the local security instructions will also take place to ensure that risk assessments take into account the actual risk the prisoner poses at the time of the escort. | 31/05/15<br><br>Head of Equalities and Safer Custody<br>&<br>Head of Security and Operations |
| 2 | The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible of their illness. | Accepted | Every effort is made to ensure that the next of kin are informed as soon as possible after a prisoner is considered to be seriously ill. A notice will be issued to family liaison officers and Duty Governors to ensure that this process is followed. | 31/05/15<br><br>Head of Equalities and Safer Custody |