



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in
February 2015 while a prisoner at HMP Stafford**

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, a prisoner at HMP Stafford who died of pneumonia as a result of cancer on 11 February 2015. He was 63 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 Stafford. The prison cooperated fully with the investigation.

In January 2011, the man was sentenced to ten years in prison and had been at Stafford since March 2012. He had a history of chronic obstructive pulmonary disease, for which he was prescribed inhalers. He had little interaction with healthcare staff at Stafford until August 2014.

On 24 August 2014, the man had breathing difficulties and a GP diagnosed a chest infection. Four days later, another GP reviewed the man and was concerned he might have fluid on the lung. He was taken to hospital that day and was admitted for treatment. Subsequent tests in September, showed a large mass on the man's lung and tests confirmed lymphoma, which had spread to the lungs. He remained in hospital and completed a course of chemotherapy. On 26 November, he was returned to Stafford. On 3 December, a scan showed that the cancer had continued to spread. The hospital admitted him for a second course of chemotherapy, which was unsuccessful. He remained in hospital and, on 9 February, he refused further treatment. He died in hospital on 11 February.

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 managers decided that he should be handcuffed when he went to hospital, without appropriate healthcare input into the risk assessment.

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 Newcomer CBE
Prisons and Probation Ombudsman

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SUMMARY

1. On 7 January 2011, the man was sentenced to ten years in prison and had been at HMP Stafford since March 2012. He had a history of chronic obstructive pulmonary disease, for which doctors prescribed inhalers.
2. On 20 August 2014, the man asked to see a GP. On Sunday 24 August, before he received an appointment, an officer asked a nurse to examine the man, who reported feeling dizzy, short of breath and had pain in his chest. An out of hours GP advised the nurse to call an ambulance. Paramedics attended and said the man had symptoms of a chest infection and did not need to go to hospital. A GP came to the prison and prescribed antibiotics.
3. On 28 August, a GP reviewed the man who was still short of breath. As well as the chest infection, the doctor was concerned that he had fluid on his lungs and sent him to hospital. The hospital confirmed the diagnosis and admitted the man. His condition deteriorated in hospital and, on 10 September, hospital staff moved him to the critical care unit. Tests showed he had lymphoma (cancer that starts in the lymph glands) and a large cancerous mass in his lung.
4. The man stayed in hospital and began a course of chemotherapy. On 14 September, a chest X-ray revealed that the chemotherapy had not worked. However, the man's condition improved a little and he moved back to a general ward. On 26 November, the hospital discharged him and considered he was mobile and able to care for himself. He went back to a standard wing at the prison, but his mobility was poor and he fell three times. A nurse planned to move him to a more suitable wing but, before this could happen, a CT scan on 3 December showed a further large swelling. He was admitted to hospital that day.
5. The man remained in hospital but his health quickly declined. On 2 February 2015, the hospital referred him for palliative care. On 9 February, he declined further active treatment and died at the hospital two days later.
6. We are satisfied that the standard of healthcare the man received at Stafford was equivalent to that he could have expected to receive in the community. However, we are concerned that managers authorised the use of restraints when he went to hospital without appropriate healthcare contributions to indicate how his health and mobility affected his risk of escape. We make one recommendation about this.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed four members of staff at Stafford on 17 March.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. We informed HM Coroner for Staffordshire of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. His sister did not have any specific matters for the investigation to consider.
12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
13. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

HMP STAFFORD

14. HMP Stafford is a medium security prison, which holds more than 700 prisoners across seven wings. Staffordshire and Stoke-on-Trent Partnership NHS Trust provides healthcare services. There are no inpatient facilities. Nurses are on duty daily between 7.45am and 5.30pm and there is a week day GP service. There is an on-call GP service outside these hours.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Stafford was in July 2011. The Inspectorate found that there was no specific policy for older prisoners or those with disabilities. Prisoners were able to access all health services reasonably quickly and there were no long waiting lists. Access to the prison GP was good and a wide range of visiting health professionals brought services into the prison. The relationship between prisoners and health service staff, and the management of lifelong conditions were both regarded as excellent.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its report for the year ending April 2014, the IMB noted that there were several vacancies for nurses, and sometimes staffing was on the verge of being critical. However, healthcare staff did well to provide a high level of service and the Board received very few complaints about health care.

Previous deaths at HMP Stafford

17. This man's death was the fourth from natural causes at Stafford since January 2013. We have raised the issue of the unjustified use of restraints for hospital escorts before.

ISSUES

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

18. On 7 January 2011, the man was sentenced to ten years in prison for sexual offences. He was transferred from HMP Birmingham to HMP Stafford on 2 March 2012. He had a history of chronic obstructive pulmonary disease (COPD - the name used for a collection of lung diseases) for which he was prescribed inhalers. He did not have any significant interaction with healthcare staff until August 2014.
19. On 20 August 2014, the man asked to see a GP as he was short of breath. There was a seven-day wait for appointments at the time and, before he had an appointment, on Sunday 24 August, an officer asked a health care assistant to examine the man, who had difficulty breathing. He said he felt dizzy, short of breath and had pain in his chest. The healthcare assistant gave him oxygen and contacted the out of hours GP who advised her to call an ambulance.
20. Paramedics attended and said the man appeared to have a chest infection. He did not need to go to hospital but should see a GP. Another out of hours GP came to the prison and examined him. He diagnosed a chest infection and prescribed antibiotics.
21. On 28 August, the man was still short of breath and a prison GP examined him. As well as the chest infection, he thought he had a possible pleural effusion (fluid on the lung). He arranged for the man to go to outside hospital the same day. The hospital admitted him with an initial diagnosis of chest infection and pleural effusion. He remained in hospital for tests but his condition began to deteriorate.
22. On 10 September, the hospital moved the man to the critical care unit and scans confirmed that he had lymphoma and a large cancerous mass in his left lung. Hospital staff discussed the man's condition with him and his sister, his next of kin.
23. There were eight days between the man first complaining of being short of breath and the GP sending him to hospital. The clinical reviewer said that initially there was no evidence of any serious problem and the timescale and management by prison healthcare staff was appropriate. We agree that healthcare staff at the prison referred the man appropriately and there was no delay in his diagnosis.

The man's clinical treatment

24. After his diagnosis, the man remained in hospital. On 11 September, he began a course of chemotherapy. Hospital doctors informed both the man and the prison that his prognosis was poor, but did not say how long they thought he would live.

25. On 14 September, a chest X-ray showed that the chemotherapy had not reduced the tumour in the man's lung. However, on 17 September, hospital staff noted his general condition began to improve and he moved back to a hospital medical ward.
26. On 2 October, a chest X-ray showed there was severe damage to his left lung. On 9 October, hospital staff inserted a Hickman line, a narrow tube to allow medication to be given directly into the bloodstream.
27. The man's condition improved significantly. On 26 November, hospital staff noted he was able to walk short distances and self-care. The hospital discharged him back to the prison later that day. Over the next few days, healthcare staff frequently reviewed him and assessed his needs.
28. On 3 December, the man went to hospital for a CT scan. This identified a new large swelling on his left side and the hospital admitted him the same day. He received intravenous antibiotics to treat cellulitis (an infection of the deeper layers of the skin). On 11 December, the hospital informed the prison healthcare team leader that the man had an infection and his tumour has increased in size. He remained in hospital.
29. On 12 and 19 December, the man was taken from outside hospital to a further outside hospital to see a consultant haematologist for a new cancer trial. However, he was too unwell to take part. On the 15 December, he began a four-day course of chemotherapy. He remained in hospital.
30. On 2 February, the hospital referred the man to the palliative care team. On 9 February, he turned down a further course of chemotherapy. He died at the hospital shortly thereafter. The coroner confirmed the cause of death was pneumonia, lymphoma that had infiltrated the chest wall and pulmonary oedema (fluid on the lungs).
31. The clinical reviewer found that the standard of healthcare the man received in prison was at least equivalent to that he could have expected to receive in the community. Prison healthcare staff managed him well in the few days he returned to prison after his diagnosis. They reviewed him frequently and discussed his condition with him. Once he was re-admitted to hospital on 3 December, healthcare staff remained in frequent contact with the hospital but did not have any direct clinical responsibility for his care. We are satisfied that prison healthcare staff managed the man's condition well and that communication with the hospital was good.

The man's location

32. On 26 November, the man returned to prison from a long stay in hospital. The discharge letter from the hospital said he was mobile and self-caring. Staff accommodated him in a single cell on the ground floor of G wing, a smaller quiet wing, which staff considered would reduce his risk of infection. He had an adapted toilet seat in his cell and staff ordered a shower seat when

his mobility issues became apparent. (He was re-admitted to hospital before this was received.)

33. A nurse told us that healthcare staff acted initially on the information provided by the hospital, which stated that the man was able to mobilise independently. After his discharge, he fell in his cell three times and the nurse told us she arranged for a move to the elderly prisoner's wing, which would allow him more access to healthcare staff. She tried to arrange for him to go back to hospital, but he was readmitted anyway on 3 December, after a scan.
34. The clinical reviewer concluded that, in retrospect, the man should not have been transferred to a standard prison wing directly from hospital. However, we are satisfied that staff made the decision based on the information provided by the hospital. As soon as it was clear his mobility was poor, staff planned to move him to a more suitable location. He was admitted to hospital shortly afterwards, before the move could take place.

Restraints, security and escorts

35. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 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 a 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 medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
36. On 28 August, when the man was taken to hospital, escort officers used handcuffs to restrain him. A risk assessment concluded he was a medium risk overall, including of escape. However, there was no healthcare input to say how his condition affected his risk of escape. Later that day, the duty manager reviewed the risk and substituted the handcuffs for an escort chain. (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). Again, there was no healthcare input. Officers removed the escort chain on 9 September when the man's health deteriorated and his condition became critical.
37. As the man's condition improved, officers reapplied the escort chain on 24 November and used handcuffs to take him back to the prison on 26 November. On 3 December, when he went to hospital for a scan he was assessed as an overall medium risk. The healthcare section of the risk assessment had a box ticked to indicate that there were no healthcare objections to the use of restraints, but there was no comment about how his health or mobility affected his risk of escape. Officers restrained him with an escort chain for the journey but this was removed for treatment and later when

the hospital admitted him. When he was taken to the second outside hospital on 12 December no restraints were used, but handcuffs were used on 19 December. At this time, the man was very ill and in a wheelchair, but again there was no considered healthcare input.

38. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. It is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process – particularly when prisoners are terminally ill. We are not satisfied that there was appropriate healthcare input into the risk assessments as the 2007 High Court judgment requires. We have raised this with Stafford before. We make the following recommendation:

The Governor and 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

39. On 9 September, hospital staff informed a senior prison manager that the man's condition was critical and that his next of kin should be informed. The senior prison manager contacted the man's sister. A prison manager acted as the prison's family liaison officer.
40. The family liaison officer arranged for the man's sister to visit him in hospital and supported her throughout his illness. When it became evident that the man was reaching the end of his life, the hospital rang his sister to advise her to attend the hospital immediately. Sadly, he died before she arrived. The hospital informed her of his death. The family liaison officer contacted the man's sister to offer her condolences and support. The man's sister expressed her gratitude in writing to the prison for the support they had given her.
41. The prison held a memorial service for the man on 25 February. The funeral was on 2 March and the prison contributed towards the costs in line with national guidance.

Compassionate release

42. Prisoners can be released from 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 12 September, the prison considered applying for compassionate release for the man. However, the hospital consultant was unable to give a clear prognosis and the application could not be progressed. He was in hospital for the majority of his illness and doctors never gave a clear life expectancy. We are satisfied that the prison appropriately considered the possibility of compassionate release.

RECOMMENDATION

The Governor and 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.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor and 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.</p>	Accepted	<p>A new risk assessment for Hospital Escort and Bed Watch was formulated in early March 2015 and issued to senior staff via e-mail on 26/3/15 by the Head of Security and Operations. This was agreed by the Governor, and put in operation on 1/5/15. The local risk assessment document will also take into account the requirements contained in the standard risk assessment form within the National Security Framework. All Senior staff undertaking risk assessments for prisoners taken to hospital have been reminded via e-mail of the legal position and that assessments should take into full account the health of a prisoner and are based on the actual risk the prisoner presents at the time. All risk assessments carried out will be monitored via external and internal audits processes</p>	<p>Completed Governor Head of Healthcare.</p>	