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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in June 2014  
while in the custody of HMP Elmley**

## ***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 June 2014, while a prisoner at HMP Elmley. He had been suffering from incurable lung cancer. He was 88 years old. I offer my condolences to his family and friends.

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

The man was sentenced to 14 years in prison in April 2014 and was sent to HMP Elmley. Doctors had diagnosed him with advanced lung cancer in August 2013 and no active treatment was possible. He had other health conditions including heart disease, high blood pressure and diabetes, for which healthcare staff monitored him. His mobility was poor. As his health deteriorated he was admitted to hospital three times in June. As the judge had been aware of his poor health at the time of his sentence, compassionate release was not granted.

On 20 June 2014, a prison GP sent the man to hospital when he reported chest pains and breathing difficulties. The hospital admitted him, but his condition deteriorated rapidly and he died in hospital seven days later.

The clinical reviewer was satisfied that the man received a good standard of care at the prison and I agree. However, I am concerned that restraints were used when he was taken to hospital. This was not justified by considered risk assessments which fully took into account his health and mobility at the time. While it did not affect the outcome for him, I am also concerned that is another case at Elmley where it is apparent that staff did not follow required emergency procedures.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**June 2015**

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## SUMMARY

1. The man was sentenced to 14 years in prison on 2 April 2014 for sexual offences and was sent to HMP Elmley.
2. The man's health was very poor and he had a number of pre-existing medical conditions at the time of his sentence. In August 2013, doctors had diagnosed him with advanced lung cancer and he took a number of medications to treat heart disease and high blood pressure. He suffered from type 2 diabetes which was diet controlled. His mobility was poor.
3. Prison healthcare staff reviewed the man frequently and he had appropriate care plans to address his health conditions. Because of his very poor health, he spent some time in hospital as an inpatient. He was restrained for some of his hospital stays, despite being assessed as low risk and having very poor mobility.
4. On 20 June 2014, the man told a nurse that he was suffering from tightness in his chest. The nurse noted that he was unable to bear his own weight. A prison GP reviewed him and, after carrying out an ECG, decided to send him to hospital by emergency ambulance. On 25 June, the prison informed his family that the hospital had admitted him and they were able to visit him.
5. The man's condition continued to deteriorate in hospital and, on 26 June, a palliative care nurse at the hospital informed healthcare staff at Elmley that he was dying. The hospital began an end of life care pathway and he died soon afterwards.
6. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Elmley was equivalent to that he could have expected to receive in the community. However, we are concerned that the use of restraints was not justified by appropriate risk assessments when he was taken to hospital. The investigation also identified that staff did not use and respond appropriately to emergency medical codes. We make two recommendations.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He visited Elmley on 20 August 2014 and interviewed three members of staff. He gave the prison's liaison officer initial feedback about the preliminary findings of the investigation.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. We informed HM Coroner for the Mid Kent and Medway district of the investigation, who confirmed 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 family to explain the investigation. His family were concerned that, despite his poor mobility, he had been expected to queue for medication in the prison.
12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, his location, security arrangements for hospital visits, liaison with his family and whether compassionate release was considered.
13. The draft report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and an action plan has been added to the end of this report.
14. The man's family received a copy of the draft report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

## **HMP Elmley**

15. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds up to 1,200 men in five wings, with a mixture of single, double and triple cells. The healthcare centre includes a 29-bed inpatient unit.

## **HM Inspectorate of Prisons**

16. The most recent inspection of HMP Elmley was in June 2014, when the Inspectorate had serious concerns about a number of aspects of the operation of the prison. In relation to healthcare, inspectors noted that their survey of prisoners showed that fewer prisoners than at comparator prisons said that their access to and the quality of health services were good. Inspectors found that nurse triage was reasonable, but access to primary care clinics was compromised by a very high non-attendance rate of up to 50%. Prisoners often missed appointments because they were not unlocked, were not told about their appointments or had to choose between them and other activities. Despite these concerns, inspectors found that the overall quality of health care was reasonably good and the inpatient unit was a decent environment with good access to therapeutic activities. However, medicines management was poor, with many instances of missed medications and inadequate dose intervals. There was a good range of mental health services.

## **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 October 2013, the IMB noted that, since the takeover of primary healthcare by South East Health (now known as IC 24) in February 2013, 45 new staff had been employed. There were plans to open clinical consulting rooms on all six houseblocks which the IMB hoped would relieve waiting times in outpatients and reduce the number of missed appointments. The IMB described healthcare staff as helpful, hardworking and cooperative.

## **Previous deaths at Elmley**

18. The man's death was one of three from natural causes at Elmley since the start of 2012. There has been one further death since. We have previously made recommendations about the risk assessment process for the use of restraints for hospital visits and about the appropriate use and response to emergency medical codes. These issues arose again in this investigation.

## **ISSUES**

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

19. On 2 April 2014, the man was sentenced to 14 years in prison for sexual offences. He was taken to HMP Elmley. He was 88 years old. It was his first time in prison.
20. A nurse carried out an initial reception health screen and noted that the man was in poor physical condition and required a walking frame to mobilise. She recorded that he suffered from a number of medical conditions, diet controlled type 2 diabetes, ischaemic heart problems (muscle damage in the heart) for which he had had a pacemaker fitted in 2006, neuropathy of both legs (nerve damage), and raised blood pressure. She also noted that he was suffering from advanced lung cancer. He said that he only had three months to live. The hospital had not confirmed this prognosis. Healthcare staff requested his community health records.
21. The man's records showed that a consultant chest physician at a hospital had diagnosed him with lung cancer in August 2013. At the time, his lung cancer was too advanced for curative treatment.
22. Healthcare staff at the prison contacted his secondary care providers and checked that he did not have any further routine follow-up appointments. His GP had discharged him from on-going care.
23. The man had been diagnosed with a terminal illness before he arrived at Elmley. We are satisfied that he was fully aware of his condition and that healthcare staff at the prison obtained relevant information to support his ongoing care. They kept him informed of the seriousness of his condition as it progressed.

### **The man's medical treatment**

24. Healthcare staff began care plans to cover the man's various health conditions, including his terminal cancer, the day he arrived. The next day, a prison GP reviewed him and prescribed medication in line with his home GP's records. The GP noted that he had signed an order indicating that he did not want to be resuscitated in the event of a cardiac or respiratory arrest. The GP discussed this with him, who was clear that his view had not changed and he wanted the order to continue. The doctor noted this in his medical records and informed the relevant people involved in his care.
25. Healthcare staff contacted the hospital departments which had been responsible for the man's secondary care before he came to prison to let them know he was now at Elmley. Healthcare staff reviewed him frequently.
26. On 25 April, a nurse referred the man to a Macmillan nurse for specialist advice on cancer care. The Macmillan nurse reviewed him on 5 May and noted that he was asymptomatic (not showing any symptoms of his condition)

and did not need her input at that time. She asked healthcare staff to refer him again at any time if his condition deteriorated.

27. In the weeks that followed, there were well documented entries in the man's medical records which show that healthcare staff frequently reviewed his care and general wellbeing. They ensured that he received his daily medication for his various conditions.
28. On 22 May at 6.56am, a nurse responded to a code blue medical emergency (which indicates a prisoner is unconscious, not breathing or has serious breathing problems). The control room did not call an ambulance. He had told officers that he was suffering from shortness of breath and had been coughing up blood throughout the night. The nurse examined him and noted that there was a negligible amount of blood and his condition was not serious enough to warrant being taken to hospital. She noted in his medical records that he appeared to be suffering from a general deterioration in his condition.
29. The man told the nurse that he was finding it increasingly difficult to have to queue for his medication. The nurse queried in his medical records whether someone could take his medication to him in his cell. She referred him for a GP review. After this, healthcare staff agreed that he should let staff know when he felt unable to queue for his medication and nurses would take it to him. He asked for this occasionally. Healthcare staff had to supervise his medication as he was sometimes confused and forgetful so could not keep it in his cell, and nurses usually encouraged him to collect it, as a way of keeping him mobile. We are satisfied that the prison made alternative arrangements to administer his medication when he requested.
30. Later that day, a GP reviewed the man and noted that he suffered from double vision and had multiple abrasions caused by bumping into things. He had been under the care of the ophthalmology department at a hospital for sight problems before he came to prison and continued to be under their care. The GP arranged to review him the next week.
31. On 30 May, the man told the GP that he was continually short of breath on exertion and had been suffering from pains in his right lower abdomen. The GP suspected a hernia and referred him for an ultrasound scan. The GP asked nurses to assess his bedsores.
32. At about 10.00am on 2 June, the man's cellmate told officers that the man had collapsed on the floor in his cell. Officers radioed a code blue emergency and a nurse responded. She noted that he had not collapsed but had felt weak when he had been queuing for his medication. When he got back to his cell he had been unable to make it to the bed and had sat on the floor. She decided to admit him to the prison's healthcare centre as an inpatient.
33. A nurse reviewed his condition and comprehensively updated his care plans when he arrived at the healthcare centre. A GP examined him and noted he seemed to be confused and had a high temperature. He noted a crackling sound in his right lung, a sign of congestion and restricted breathing and

suspected pneumonia. As a precaution, he arranged for him to go to hospital by emergency ambulance. The hospital admitted him as an inpatient for three days until his condition stabilised. There was no evidence of pneumonia and he went back to the prison healthcare centre as an inpatient. Healthcare staff continued to monitor and care for him.

34. On 8 June, the man complained to a healthcare assistant that he had pain in the centre of his chest. The healthcare assistant carried out an ECG (an electrocardiograph which is used to monitor the rhythmic output of the heart) and faxed the results to the hospital. The duty doctor advised that he should be sent by emergency ambulance to another hospital. The hospital admitted him as an inpatient.
35. The man's condition improved and he returned to Elmley on 19 June. While he was in hospital, hospital staff had referred him for a single fraction of palliative radiotherapy (which is given to ease the symptoms of cancer).
36. The next day, 20 June, the man complained to a nurse of tightness in his chest. The nurse noted that he was unable to bear his own weight and asked a prison GP to review him. The GP noted that he had numerous bed sores, appeared confused, was weak in his legs and had a crackling sound in his lungs. He carried out an ECG and noted an abnormality in his heartbeat. He contacted the duty medical registrar at the hospital, who advised that he should be taken to the hospital by emergency ambulance.
37. During his first four days in hospital, hospital staff considered that the man's condition was improving and that it may be possible to discharge him back to prison.
38. However, the man's condition deteriorated in hospital and, on 26 June, a palliative care nurse at the hospital informed healthcare staff at Elmley that he was dying. The hospital began an end of life care pathway. He died shortly afterwards.
39. We note the clinical reviewer's assessment that the man received an appropriate standard of care at Elmley. He had no active treatment for cancer, but healthcare staff monitored him frequently and ensured he went to hospital when necessary.
40. Although it did not affect the outcome for the man, we are concerned that, on at least two occasions, staff called an emergency code blue but the control room did not call an ambulance automatically, as required by Prison Instruction (PSI 03/2013) and Elmley's own local protocol. It appears that some staff at Elmley use a code blue to request healthcare staff to attend urgently rather than because there is an immediate medical life-threatening emergency. However, it is important that staff use codes correctly and call an ambulance immediately when an emergency code is used. We have raised this matter with Elmley before, during an investigation into a death at the prison in February 2014. PSI 03/2013 makes it clear that it should not be a requirement for healthcare staff to attend before calling an ambulance. It says

that it is better to request an ambulance that can be cancelled if healthcare staff assess that one is not required. The prison needs to ensure that staff use emergency codes appropriately and follow the national and local instructions. We repeat our previous recommendation:

**The Governor and Head of Healthcare should ensure that all staff are made aware of and understand the prison's protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies, including appropriate use of emergency codes.**

### **The man's location**

41. When the man first arrived at Elmley, he was admitted to the prison's healthcare centre as an inpatient. He remained there until 15 April 2014, when healthcare staff assessed him as being fit enough to live on a standard residential unit. He was able to mobilise with a walking frame and did not require any special adaptations to his cell. As his condition deteriorated, his cellmate acted as his carer, collected his meals for him and helped him with basic daily tasks.
42. The man said that he found it increasingly difficult to use his walking frame and, on 30 May, the GP referred him to the occupational health team at Elmley to assess whether he needed a wheelchair or a specially adapted cell for disabled prisoners. Before the assessment was done, he moved back to the healthcare centre as an inpatient. He remained there until his final hospital admission on 20 June.
43. Although the man experienced some difficulty mobilising when he was living in the houseblock, we are satisfied that he was appropriately located throughout his illness.

### **Restraints, security and escorts**

44. 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.
45. 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 said that restraining by handcuffs 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.

46. The man attended hospital as an inpatient three times. His risk assessments indicated that he was a low risk of escape and a low risk to staff and the public should he do so. Despite his age, mobility problems and extremely poor health, each time the prison used an escort chain to restrain him. (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.)
47. Officers restrained the man for a hospital stay at hospital between 3 and 6 June. When he went back to the hospital on 8 June, managers again authorised an escort chain to be used, although the risk assessment noted he was low risk across all areas and required help to mobilise. The records show that officers removed the restraints shortly after he arrived at hospital. They did not use them again for the rest of his stay.
48. On 20 June, when the man went to hospital for the last time, the risk assessments again showed that he was low risk in all areas. There was no healthcare contribution as the court judgement requires, but a manager at Elmley noted that he had “no mobility”. Despite this, the Governor authorised a two person escort and use of an escort chain. The escort chain was removed shortly after he was admitted as an inpatient. There is no evidence that he was a greater risk in the ambulance than in hospital.
49. The next day, 21 June, the manager instructed the escorting officers to apply the escort chain again, after a hospital manager had queried why the man was not restrained. This decision was not based on any increase in risk. He remained restrained until the morning of 22 June, when one of the escort officers agreed with hospital staff that restraints were not necessary. The officer phoned the duty governor, who authorised the removal of the escort chain.
50. Although we are pleased to note that for much of the time during his last two hospital admissions, escort officers did not use restraints, we are not satisfied that the man’s age, infirmity and health was properly taken into account during the risk assessment process. It is difficult to see, on the basis of the assessments, how the use of restraints was justified. It is particularly concerning that a prison manager decided to restrain him on the basis of a query from a hospital manager rather than because of any change in his risk, and that it took one of the escort officers to resolve this. 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**

51. Prison Rule 22 says that if a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin". For four days after the man was admitted to hospital, medical staff believed that his condition was improving and that it was possible that he could be discharged back to Elmley.
52. However, once the man's condition deteriorated, on 25 June, the prison informed his daughter that her father had been admitted to hospital and continued to keep her informed of his condition. She, and other members of his family, visited him at the hospital during the time before his death.
53. Shortly after the man died, chaplain at Elmley was about to go and inform his daughter in person that her father had died, when he learnt that the hospital had already let her know. He and an operational manager at Elmley went to see her that afternoon and spoke to her about the arrangements after her father's death. She did not want to visit Elmley to see where her father had lived and did not want the prison to be represented at his funeral.
54. The chaplain remained in contact with the man's daughter. The funeral was held on 17 July and the prison offered a financial contribution in line with national guidance. We are satisfied that when his condition deteriorated, the prison appropriately informed his family. We are satisfied that the prison had appropriate arrangements to liaise with his family.

## **Compassionate release**

55. 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. Early release on compassionate grounds is not normally allowed if it is based on facts of which the sentencing court was aware.
56. On 7 April, the prison applied for the man's early release on compassionate grounds. That application was refused as he had been sentenced just five days earlier and there had been no opportunity to assess his risk. Although his condition was unlikely to improve, there was no clear prognosis for his future. It was also noted that he had failed to comply with the terms of his bail conditions before being sent to prison.
57. On 26 June, the day before the man died, the prison made another application for release on compassionate grounds on his behalf. The application was again refused.
58. We are satisfied that the man's application for compassionate release was properly assessed. We understand that the sentencing court was fully aware of his terminal condition when he was sentenced to prison, less than three months before his death and, therefore, release would have been unlikely.

## **RECOMMENDATIONS**

1. The Governor and Head of Healthcare should ensure that all staff are made aware of and understand the prison's protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies, including appropriate use of emergency codes.
2. 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
1	The Governor and Head of Healthcare should ensure that all staff are made aware of and understand the prison's protocol in respect of PSI 03/2013 and their responsibilities during medical emergencies, including appropriate use of emergency codes.	Accepted	A notice to staff has been issued to ensure that Code Red and Code Blue calls are actioned in accordance with PSI 03/2013.	Completed Governor/Head of Healthcare
2	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.	Accepted	Guidance has been given to all staff who complete risk assessments for hospital non-emergency and emergency admission to outside hospital. Staff must fully take into account the health and welfare of the prisoner concerned.	Completed Governor/Head of Healthcare