Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr George Joseph, a prisoner at HMP Belmarsh, in April 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr George Joseph died of a brain tumour in April 2015, while a prisoner at HMP Belmarsh. He was 78 years old. I offer my condolences to Mr Joseph's family and friends.

I consider that Mr Joseph received a good standard of care at Belmarsh, equivalent to that he could have expected to receive in the community. However, I am not satisfied that the level of restraints used when Mr Joseph was taken to hospital was justified by fully considered risk assessments.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2015**

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Summary

Events

1. Mr George Joseph was remanded to prison in October 2013. He transferred to HMP Belmarsh in March 2014 and was sentenced to life imprisonment in May 2014. He had type two diabetes and chronic kidney disease. Healthcare staff frequently reviewed and managed these conditions.

2. In January 2015, Mr Joseph reported pins and needles, tingling in his body and said he was becoming forgetful. Prison staff were concerned that he sometimes appeared confused. On 7 February, healthcare staff moved Mr Joseph to the prison's healthcare unit, as his symptoms worsened. On 12 February, he was admitted to hospital for tests and a scan showed that he had a brain tumour.

3. Mr Joseph returned to the prison on 24 February. On 20 March, the hospital informed prison healthcare staff that Mr Joseph's condition was not operable and he should be cared for palliatively. At a care meeting on 1 April, staff decided to move Mr Joseph to the palliative care suite in the prison's healthcare unit for 24-hour nursing care.

4. On 8 April, Mr Joseph developed a chest infection but was unable to take antibiotics. On 9 April, his condition deteriorated and he was admitted to hospital. He remained in hospital until he died.

Findings

5. We are satisfied that Mr Joseph's care at Belmarsh, in relation to his brain tumour, was equivalent to that he could have expected to receive in the community. His diagnosis was prompt and the prison healthcare staff worked well with hospital and community nurses to provide a good standard of end of life care.

6. Officers did not use restraints when Mr Joseph was admitted to hospital for the final time in April. However, managers decided he should be restrained, including by double handcuffs on three earlier occasions. We do not consider the level of restraint used was justified by risk assessments, which fully took into account his health and condition at the time.

Recommendations

- 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.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

8. NHS England commissioned a clinical reviewer to review Mr Joseph's clinical care at the prison.

9. The investigator obtained copies of relevant extracts from Mr Joseph's prison and medical records. She and the clinical reviewer interviewed four members of staff at Belmarsh on 15 June. She interviewed a prisoner by telephone on 15 July.

10. We informed HM Coroner for Southwark of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Joseph's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no specific questions or concerns but wanted to know what had happened in the weeks before her brother's death.

12. The investigation has assessed the main issues involved in Mr Joseph'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 initial report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

14. Mr Joseph's family received a copy of the initial report. They did not raise any further issues, which have affected the factual accuracy of the report.

15. The initial report was also shared with the clinical reviewer. She raised a number of factual inaccuracies and the report has been amended accordingly.

Background Information

HMP Belmarsh

16. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds over 900 men. Care UK provided healthcare services at the prison until April 2015. Oxleas NHS Trust is now the healthcare provider. There is 24-hour healthcare cover, including an inpatient unit. There are healthcare facilities on each of the houseblocks, as well as in reception, and the first night centre.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Belmarsh was in February 2015. Inspectors found that health services at the prison were improving and most nurses provided good care. Inspectors noted that the prison had developed a strategy to support prisoners with palliative and end of life needs and two cells in the inpatient unit were being refurbished for this purpose.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 June 2014, the IMB reported that the healthcare unit had had a settled year. Staffing levels continued to improve with only a few vacancies. A programme to refurbish treatment rooms was ongoing.

Previous deaths at HMP Belmarsh

19. Mr Joseph was the fourth prisoner to die from natural causes at Belmarsh since the start of 2013. We have previously recommended that the use of restraints for elderly and infirm prisoners should be justified by fully considered risk assessments.

Findings

The diagnosis of Mr Joseph's terminal illness and informing him of his condition

20. On 9 October 2013, Mr George Joseph was remanded to prison and had been at HMP Belmarsh since 24 March 2014. On 22 May 2014, he was sentenced to life imprisonment. Mr Joseph had type two diabetes and chronic kidney disease. Healthcare staff frequently reviewed and monitored these conditions.

21. On 31 January 2015, a nurse booked a GP appointment for Mr Joseph after he reported experiencing pins and needles and tingling feelings in his body, head and face. The next day, she saw Mr Joseph again when officers said that he appeared to be confused. She noted that Mr Joseph was tearful and said that he was becoming forgetful.

22. The next day, 2 February, a prison GP examined Mr Joseph and noted he possibly required a MRI scan of his brain, a referral to a memory loss clinic and counselling.

23. On 3 February, a nurse saw Mr Joseph when officers were again concerned about his state of confusion. She referred Mr Joseph for an appointment with the mental health team. On 7 February, Mr Joseph's cellmate told officers that Mr Joseph was getting worse. He was waking at night and was incontinent. Healthcare staff admitted him to the healthcare unit as an inpatient, later that day.

24. On 9 February, a prison psychiatrist assessed Mr Joseph. The psychiatrist had no significant concerns about Mr Joseph's mental state and suggested a GP should rule out an organic cause for his confusion before the mental health team reviewed him further.

25. On 11 February, a prison GP arranged for Mr Joseph to go to hospital after blood and urine tests results were abnormal. The next day a hospital admitted Mr Joseph for tests. On 13 February, a CT scan revealed a mass in his brain. Neurological surgeons at another hospital reviewed Mr Joseph and concluded that he had a glioma brain tumour (malignant tumour on the brain). On 24 February, the hospital discharged Mr Joseph and he went back to the healthcare unit at Belmarsh.

26. On 25 February, a prison GP explained Mr Joseph's condition to him but, because of his poor memory and confusion, was not sure he understood. He tried to call Mr Joseph's family to discuss his condition but was unable to reach them at the time.

27. The clinical reviewer noted that it took just two weeks from Mr Joseph's initial symptoms to the diagnosis of a brain tumour. We are satisfied that the GP referred Mr Joseph appropriately and promptly.

Mr Joseph's medical treatment

28. Healthcare staff continued to look after Mr Joseph as an inpatient in the healthcare unit. On 12 March, a neuro-oncology consultant at the hospital

examined Mr Joseph, explained his diagnosis to him and said that she was going to discuss his case with surgeons.

29. On 16 March, a prison GP noted Mr Joseph was disorientated and prone to falls. He referred Mr Joseph to a community hospice for advice on palliative care and management. A nurse wrote a care plan, including advice to nurses about how to interact with Mr Joseph and assess whether he was in pain.

30. On 20 March, the oncology team at the hospital informed the prison's healthcare inpatient manager that Mr Joseph was too unwell for the operation. A prison GP told us that hospital staff had informed Mr Joseph of this. Mr Joseph's condition continued to decline, his mobility was limited and he was increasingly confused.

31. On 1 April, a meeting involving a clinical specialist from the Greenwich and Bexley Community Hospice outreach team, healthcare managers, prison managers and Mr Joseph discussed Mr Joseph's care. The meeting agreed that Mr Joseph should move to the palliative care cell that day, with 24-hour nursing care. His cell door was to remain open at all times. Mr Joseph was too distressed to discuss whether he wanted staff to attempt resuscitation if his heart or breathing stopped.

32. On 2 April, a nurse wrote to a prison GP with a list of medications for him to prescribe to manage pain and anxiety in anticipation of Mr Joseph's end of life care.

33. On 8 April, Mr Joseph developed a chesty cough and a prison GP prescribed antibiotics. The next day, a GP noted Mr Joseph was unable to swallow the antibiotics and prescribed a liquid form. However, Mr Joseph could not take this medication either. The GP noted his condition had deteriorated significantly and arranged for him to be admitted to hospital.

34. On 12 April, a nurse visited Mr Joseph in hospital and hospital staff said he was not responding to treatment and was only receiving pain relief. The hospital's palliative care team was considering whether Mr Joseph he could move to a hospice. The next day, a nurse told prison healthcare staff that Mr Joseph was too ill to be moved to a hospice.

35. On 15 April, a hospital palliative care consultant informed the prison that Mr Joseph's condition would not improve. Mr Joseph died in hospital a few days later.

36. The clinical reviewer considered that there was good coordination between the prison staff and NHS staff to manage Mr Joseph's care effectively. We are satisfied that, in relation to his brain tumour, Mr Joseph's care was equivalent to that he could have expected to receive in the community.

Mr Joseph's location

37. On 7 February, seven days after his first symptoms of a brain tumour, healthcare staff moved Mr Joseph to the prison's inpatient unit. On 1 April, he moved to a special palliative care cell in the inpatient unit and received 24-hour nursing care.

38. From 9 April until his death, Mr Joseph was cared for in hospital. Mr Joseph's family had asked if he could move to a hospice. However, the hospital considered he was not well enough for a move. We are satisfied that Mr Joseph was located appropriately during his illness.

Restraints, security and escorts

39. 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.

40. Mr Joseph went to hospital on 12 February 2015 for tests. A custodial manager assessed him as low risk to the public and a low risk of escape. She authorised the use of double handcuffs. (Double cuffing means that the prisoner has his hands cuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs.) On 13 February, a prison manager reviewed Mr Joseph's risk assessment and reduced the restraint to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

41. Mr Joseph went to hospital again on 10 March and 12 March. By this time, his health had deteriorated significantly, he was confused and his mobility was limited. On 10 March, a prison manager and, on 12 March, a custodial manager, each assessed him as a low risk of escape and healthcare staff noted he was terminally ill. Both times, the managers decided that staff should use handcuffs to restrain Mr Joseph on the journey to hospital and an escort chain afterwards. When Mr Joseph went to hospital for the final time on 9 April, staff did not restrain him.

42. The use of double handcuffs is usually required for moving category A or category B prisoners in good health. Mr Joseph was a category B prisoner, but he was elderly and in very poor health. It is difficult to see how the use of double handcuffs on 12 February was justified and we note that a manager reduced this to an escort chain the next day. In March, Mr Joseph's condition had deteriorated significantly and he was terminally ill. Mr Joseph was assessed as at low risk of escape, he had limited mobility, was elderly and dying. We are not satisfied that managers appropriately considered these factors when authorising the use of restraints, as the 2007 High Court judgment requires. 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 Mr Joseph's family

43. Mr Joseph's nominated next of kin was his sister. It is not clear when the prison first contacted Mr Joseph's sister but a custodial manager arranged for Mr Joseph's sister and other family members to visit him in the healthcare unit on 11 March and twice afterwards. She kept his family informed of his condition. The prison informed Mr Joseph's sister when he was taken to hospital on 9 April and she was able to visit him there.

44. When Mr Joseph died in hospital, hospital staff informed Mr Joseph's family. A custodial manager rang Mr Joseph's sister to offer condolences and arranged to visit her at her home that afternoon for support and guidance. Mr Joseph's funeral was on 11 May and the prison contributed towards the costs in line with national policy.

45. We consider that the custodial manager appropriately supported Mr Joseph's family and kept then informed about his condition.

Compassionate release

46. Prisoners can be released early 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.

47. On 16 March, a prison GP noted that an application for compassionate release should be considered, but Mr Joseph did not have a clear prognosis at that point. On 20 March, when the hospital decided Mr Joseph was too unwell for the operation there was still no clear prognosis.

48. On 16 April, when Mr Joseph's condition was critical, a senior prison manager made a compassionate release application on his behalf. Sadly, Mr Joseph died before a decision was made.

49. While it might have been prudent to have made an application earlier, we understand that the nature of Mr Joseph's illness meant that it was difficult for doctors to give an accurate estimate of life expectancy. We are satisfied that the prison considered the possibility of compassionate release. We note that after Mr Joseph was admitted to hospital on 8 April, he soon became too ill to be moved and a successful application would have had little practical effect.

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