Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Eastwood, a prisoner at HMP Lindholme in April 2015

A report by the Prisons and Probation Ombudsman
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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 Stephen Eastwood died of prostate cancer at hospital in April 2015. He was 58 years old. I offer my condolences to Mr Eastwood's family and friends.

The investigation found that there was a significant delay in diagnosing Mr Eastwood's cancer. Principally, this was because the hospital downgraded an urgent referral, but I consider that healthcare staff at the prison should have pursued this more actively. Mr Eastwood's standard of healthcare at the prison was generally of appropriate. However, I am concerned that, when his condition declined in his last few days at Lindholme, nurses did not refer him urgently for review and he did not receive the same standard of care as previously. When Mr Eastwood was admitted to hospital a few weeks before his death, I am not satisfied that the use of restraints was justified by a fully considered risk assessment which took into account his health and mobility at the time.

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**

Contents

Summary

Events

1. Mr Stephen Eastwood had been at Lindholme since 18 January 2013. In July and August 2013, Mr Eastwood reported prostate problems. A prison GP prescribed medication to ease his symptoms and requested blood tests. The tests revealed abnormalities. A doctor examined him six days later and referred him urgently to a urology specialist under the NHS pathway, which requires a person suspected of having cancer to be seen, by a specialist within two weeks. The referral was not sent until three days after that.

2. Mr Eastwood did not see a specialist until February 2014, six months after the referral, as the hospital had downgraded the priority. No one from the prison actively followed this up. At the appointment in February, he was diagnosed with prostate cancer. Mr Eastwood transferred temporarily to HMP Hatfield between May and August 2014 and received radiotherapy at a hospital in Sheffield.

3. In December 2014 and mid-January 2015, Mr Eastwood reported persistent chest pain. At the end of January 2015, in addition to chest pain, Mr Eastwood developed symptoms of numbness in his leg, reduced mobility and difficulty eating. Nurses did not arrange an urgent review. On 1 February 2015, his condition worsened. Initially a nurse postponed examining him, but sent him to hospital later that day. The hospital found that Mr Eastwood's cancer had spread to his ribs, liver and spine. Officers used an escort chain to restrain him for four days in hospital. He remained in hospital and died there in April.

Findings

4. We are concerned that initially there was a significant delay in Mr Eastwood receiving a specialist appointment and diagnosis of his cancer. This was partly because healthcare staff at the prison did not actively pursue the urgent referral to an urologist, but most of the delay was caused by the hospital, which is not within the remit of this investigation. Mr Eastwood's subsequent medical treatment was satisfactory, but when his condition worsened towards the end of January 2015, he did not get the urgent attention and care we would have expected.

5. We are concerned that, in spite of his poor health and limited mobility, restraints were used when Mr Eastwood went to hospital on 1 February and not removed until 5 February, at his family's request. We are not satisfied that the use of restraints was justified by a fully considered risk assessment

Recommendations

- The Head of Healthcare should ensure there is a clear and auditable process for urgent hospital referrals to be sent immediately as a priority, monitored and followed up as required.
- The Head of Healthcare should ensure that nurses take appropriate clinical action when seriously ill prisoners report additional concerning symptoms, and

that the standard of care delivered reflects Care Quality Commission and Royal College of Nursing standards for privacy and dignity of care.

- 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

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

7. The investigator obtained copies of relevant extracts from Mr Eastwood's prison and medical records.

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

9. We informed HM Coroner for South Yorkshire East District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Eastwood's stepson to explain the investigation and to ask if he had any matters his family wanted the investigation to consider. He had concerns about Mr Eastwood's standard of medical care at the prison and that he had missed hospital appointments.

11. The investigation has assessed the main issues involved in Mr Eastwood'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.

12. Mr Eastwood's family received a copy of the initial report. They did not make any comments. The prison considered our initial report and recommendations, which they have accepted. The prison has also submitted an action plan and this is included at the end of the report.

Background Information

HMP Lindholme

13. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic, some specialist services and out-of-hours GPs.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of HMP Lindholme was in February 2013. Inspectors commented that there were significant problems at the prison. However, healthcare provision was reasonably good, with a range of services that met prisoners' needs.

Independent Monitoring Board

15. 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 31 January 2015, the IMB considered that healthcare provision was adequate. However, the Board was not satisfied with the arrangements for escorting prisoners to hospital for consultations or treatments and considered that prison operational requirements took precedence over medical needs.

Previous deaths at HMP Lindholme

16. Mr Eastwood was the second prisoner to die from natural causes since 2011. There were no significant similarities with the circumstances of the previous death.

FINDINGS

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

17. On 13 July 2012, Mr Stephen Eastwood was remanded to HMP Doncaster. On 14 December, he was convicted of manslaughter and sentenced to eight years in prison. He transferred to HMP Lindholme on 18 January 2013.

18. On 16 July 2013, Mr Eastwood told a nurse that he was having prostate problems. He was urinating more frequently and his bladder still felt full after doing so. She referred him to a prison GP for an urgent assessment and took a blood sample to check his level of prostate-specific antigen (PSA - a protein produced by the prostate gland). A high PSA level can indicate cancer.

19. A prison GP reviewed the blood test results on 23 July. The results showed a high PSA level at 24.87. (The normal level is under 5.) The GP noted Mr Eastwood would need a GP examination and that Mr Eastwood had a scheduled GP appointment in six days with another GP. He told the GP about the results.

20. On 29 July, the GP checked Mr Eastwood's prostate by digital rectal examination, and noted a large smooth prostrate and no rectal mass. He prescribed Tamsulosin, a medication to help Mr Eastwood pass urine more easily and arranged another blood test. He referred him urgently to the urology clinic at hospital, under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. A prison administrator sent the referral, three days later, on 1 August.

21. Mr Eastwood had a blood test on 5 August, which showed another high PSA level of 25.57, indicative of either prostate cancer or a condition such as an enlarged prostate gland. The GP reviewed Mr Eastwood on 8 August and prescribed Tamsulosin for a further two weeks, with a plan to change to another medication if there was no improvement. On 22 August, the GP asked administration staff to check the progress of the urgent hospital referral. There is no evidence that they did.

22. On 17 October 2013, an administrator noted in Mr Eastwood's medical records that the hospital had graded the referral as routine, for which there was a 12-14 week wait. Mr Eastwood initially received an appointment for November. The hospital then postponed this to February 2013. The prison did not record any reason for the delay or follow it up.

23. Mr Eastwood attended his hospital appointment on 7 February 2014. When he got back to Lindholme later that day, he told a nurse that he had been diagnosed with prostate cancer. A consultant urologist wrote to the prison on 7 February confirming the diagnosis.

24. The clinical reviewer was satisfied that Mr Eastwood's initial care was of a good standard and the doctor appropriately made a referral for suspected cancer. However, administrative staff took three days to send the referral, which should have been sent immediately. Significant delays after that were primarily the responsibility of the hospital but we consider that healthcare staff at the prison

should have actively checked the progress of the referral and asked the hospital why they had changed the priority and then postponed the initial hospital appointment. Further information might have allowed the prison GP to negotiate a more urgent assessment. The hospital delays are outside the remit of this investigation. However, the clinical reviewer has made a recommendations to NHS England that the reasons for the delays should be further investigated. We do not know whether an earlier diagnosis would have had affected the outcome for Mr Eastwood. We make the following recommendation:

The Head of Healthcare should ensure there is a clear and auditable process for urgent hospital referrals to be sent immediately as a priority, monitored and followed up as required.

Mr Eastwood's medical treatment

25. After his diagnosis, the multidisciplinary cancer team at the hospital supervised and managed Mr Eastwood's care. On 19 May 2014, Mr Eastwood transferred to HMP Hatfield, from where he had radiotherapy at another hospital. His treatment began on 30 June. There was frequent contact between HMP Lindholme, HMP Hatfield and the hospital teams. Records show nurses at HMP Hatfield looked after him well. Healthcare staff offered him support and reviewed him frequently.

26. The clinical reviewer said that the care and support from Hatfield healthcare staff during Mr Eastwood's radiotherapy was excellent and above that which he could have expected in the community. I agree that the care he received at Hatfield was commendable.

27. On 19 August 2014, Mr Eastwood returned to HMP Lindholme. A nurse completed a thorough reception health assessment. She noted that he was due to have a follow up appointment in six weeks at hospital and referred him to the GP for review.

28. The next day, a locum GP prescribed antibiotics for MRSA, diagnosed at Hatfield, and E45 cream for sore skin. Mr Eastwood told him he had continuous bleeding from his rectum. The GP referred him urgently to the hospital general surgery department. A nurse met Mr Eastwood to offer support.

29. On 4 September, an administrator received a telephone call from the hospital, who said the hospital had graded the referral as routine and scheduled an appointment for 30 October. She discussed this with the locum GP, who said Mr Eastwood should be seen sooner. The hospital brought the appointment forward to 16 October.

30. At Mr Eastwood's hospital appointment on 16 October, a colorectal specialist thought the bleeding might be due to damage or inflammation after radiotherapy. He arranged for Mr Eastwood to have a colon and rectal examination with a camera, on 6 November. However, on 5 November, Mr Eastwood signed a disclaimer that he did not want to attend the appointment, as the bleeding had stopped.

31. On 15 December, Mr Eastwood told a nurse that he had been suffering from chest pain for nine days. A prison GP sent him to the accident and emergency department at hospital. The hospital diagnosed musculoskeletal pain and he returned to prison.

32. On 12 January 2015, a nurse examined Mr Eastwood as he complained of shortness of breath, chest pain and said he could not lie on his left side. She referred him to a GP, who prescribed painkillers and ordered an urgent X-ray.

33. On Saturday 24 January, Mr Eastwood told a nurse that he had been coughing up blood. She made an appointment for him to see the GP on Monday. The GP reviewed him on 26 January and suspected his symptoms were related to the prostate cancer. He advised him to rest in his cell for a week and asked healthcare staff to chase the results of the chest X-ray. There is no record that staff followed this up.

34. On 29 January, Mr Eastwood collapsed in his cell. A nurse noted his blood pressure was 130/78, which was slightly high and his pulse was 103. She told him to rest in his cell and noted he should be reviewed the next day. An entry in his medical records on 30 January showed that he did not attend an appointment for a nurse assessment, but there is no record that this was followed up. At 10.05am on Saturday 31 January, wing staff asked a nurse to check Mr Eastwood and he told a nurse that he had no feeling down his left side. She told him to rest in his chair and nurses would check on him in the afternoon. When another nurse checked him at 5.14pm, he was unable to walk properly. She advised that he should try to move around to ease his numbness and he would be reviewed the next day. She made a GP appointment for Monday 2 February.

35. On Sunday 1 February, wing staff again asked for a nurse to see Mr Eastwood and a nurse went to see him at 8.30am. Mr Eastwood said he could not get out of bed, as his legs were numb. As a result, he had been incontinent of urine. She told him she could not examine him unless he was “decent” and told wing staff to call her to assess him when he was out of bed.

36. Mr Eastwood’s cellmate lifted him out of bed, as he was dizzy and unable to get up himself. At 10.30am, wing staff asked the nurse to come back. The nurse noted his left leg was weak and he had no support from his right leg. She took his vital signs. His blood pressure, temperature and breath sounds were normal. His pulse was the high end of the normal range at 100, which his oxygen level at 94-95 was at the low end of the normal range.

37. The nurse reviewed Mr Eastwood again at lunchtime (although she did not document this until 4.49pm). Mr Eastwood told her he had been constipated for the previous six days and was having difficulties eating. She also noted that his symptoms had not changed and said she would check him again at teatime.

38. At 5.02pm, the nurse responded to an urgent call from wing staff, as Mr Eastwood had been incontinent of faeces. There is no record that she assessed him, but she asked for a non-emergency ambulance to take him to hospital.

39. Mr Eastwood was admitted to hospital, where tests showed the cancer had spread to his rib, liver and spine. The damage to his spine had been the cause of his weakness and the hospital treated him as a spinal patient to prevent nerve damage. On 3 February, a nurse noted that Mr Eastwood had been transferred to hospital the previous day and that he was to be given palliative care only. She noted that he was due to return to another hospital.

40. Two Modern Matrons visited Mr Eastwood on 10 February to discuss his care when he returned to prison. On 17 March, the discharge planning team at the hospital said that Mr Eastwood's life expectancy was less than three months. Mr Eastwood remained in hospital, where his condition continued to decline. He died in hospital in April.

41. We are satisfied that healthcare staff offered appropriate support and advice to Mr Eastwood throughout his treatment for prostate cancer. However, when his condition deteriorated between 29 January and 1 February 2015, nurses did not take full account of his acute symptoms in the context of his medical history. They did not seek advice and treatment as quickly as they should have done, as his symptoms were indicative of a deteriorating patient who needed a more thorough medical assessment. The nurse's initial decision not to examine Mr Eastwood on 1 February, does not indicate a caring approach and the clinical reviewer considered that his symptoms should have been assessed urgently. We make the following recommendation:

    The Head of Healthcare should ensure that nurses take appropriate clinical action when seriously ill prisoners report additional concerning symptoms, and that the standard of care delivered reflects Care Quality Commission and Royal College of Nursing standards for privacy and dignity of care.

Mr Eastwood's location

42. When Mr Eastwood's cancer was first diagnosed, he had a standard cell at Lindholme. In May 2014, he was re-categorised to D, the lowest security category. He moved to HMP Hatfield, an open prison from where he attended radiotherapy sessions at hospital between May and August 2014. After his treatment, a new offender manager was concerned that he had not completed any offending behaviour work and she would not agree to any further temporary release. She did not consider that his risk had changed but contended that it had not been appropriately assessed previously. Mr Eastwood was recategorised to C and returned to Lindholme. We have not assessed the merits of the categorisation decision, as Lindholme offered Mr Eastwood appropriate accommodation.

43. From 1 February 2015, Mr Eastwood was accommodated in hospital. On 26 February, a nurse noted that she had spoken to a hospital doctor and they had agreed that it was not safe or appropriate to discharge Mr Eastwood back to Lindholme. She later contacted the complex needs discharge team, who agreed to look for a nursing home as he would need 24-hour care. However, Mr Eastwood remained in hospital until he died in April. We are satisfied he was appropriately located during the course of 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. 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.

45. Mr Eastwood had a terminal illness and was in a very poor condition, with little or no mobility, when he was admitted to hospital for the final time on 1 February 2015. The medical section of the risk assessment was blank and unsigned. There was therefore no information about his condition and how it would have affected his risk of escape. The security section noted Mr Eastwood's level of risk was low in every category. However, a prison manager concluded that two officers should escort Mr Eastwood and use 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). It is difficult to see how the manager reached the decision that Mr Eastwood was a risk of escape or re-offending on the information provided, when he was in such a weak condition and escorted by two officers.

46. On 5 February, Mr Eastwood's stepson questioned the need for Mr Eastwood to be restrained. A prison manager spoke to the hospital consultant and decided the restraints should be removed and the staffing levels reduced. The restraints were not used again.

47. 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 do not consider that staff appropriately assessed Mr Eastwood's risk, or took fully into account his condition at the time. 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 Eastwood's family

48. An officer was appointed as the prison's family liaison officer on 5 February 2015, shortly after Mr Eastwood was told that his cancer was terminal. The officer visited Mr Eastwood in hospital and contacted his stepson, who he had named

as his next of kin. He kept in touch with Mr Eastwood and his stepson. He gave his stepson updates on Mr Eastwood's condition and arranged visits.

49. When Mr Eastwood died, the family liaison officer telephoned Mr Eastwood's stepson to break the news, as they had agreed in advance. The Governor and family liaison officer visited him the next day. In line with Prison Service policy, the prison contributed to the funeral costs. We are satisfied the prison kept Mr Eastwood's family informed when his condition deteriorated significantly, and that contact after he died was appropriate.

Compassionate release

50. 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.

51. On 17 March 2015, the prison started an application for compassionate release as Mr Eastwood's life expectancy prognosis was then less than three months. Staff collated relevant information, but, sadly, Mr Eastwood died before a decision was made. We are satisfied that compassionate release was appropriately considered.

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