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 in November 2014 while a prisoner at HMP Lewes. He was 51 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Lewes was undertaken. The prison co-operated fully with the investigation.

In February 2014, the man was sentenced to five years in prison and was sent to HMP Lewes. He had a history of alcoholism and had been diagnosed with hepatitis C. Doctors prescribed him medication for the symptoms of alcohol withdrawal and referred him for hepatitis C treatment. In March 2014, the results of an ultrasound scan showed he was suffering from liver cirrhosis and an enlarged liver and spleen.

In July 2014, a liver specialist from the hospital referred the man for hepatitis C treatment as part of the national hepatitis early access programme. In September 2014, during a routine assessment, a hospital consultant found his liver function had deteriorated. An MRI scan indicated a likely diagnosis of liver cancer. Active treatment was not possible and he received palliative care in the prison's inpatient unit. On 27 October, he was admitted to hospital after his condition deteriorated. He remained in hospital until he died.

I am satisfied that there was no delay in the man's diagnosis and that healthcare staff at both the hospital and the prison kept him well informed about his condition. I consider that he received good medical care at Lewes. However, I am concerned that despite his ill health and low risk, officers restrained him when he went to hospital. This is something I have raised before with Lewes and the Governor will need to assure himself that lessons are learnt.

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. On 3 February 2014, the man was sentenced to five years in prison for firearms offences and sent to HMP Lewes.

2. The man had a history of alcoholism and had hepatitis C. Doctors prescribed medication for the symptoms of alcohol withdrawal and referred him for hepatitis C treatment.

3. The results of an ultrasound scan on 17 March showed the man was suffering from liver cirrhosis and an enlarged liver and spleen. An endoscopy on 20 June showed he was suffering from oesophageal varices (enlarged veins in the lower part of the oesophagus) and portal hypertension (high blood pressure in the veins which carry blood to the liver), both complications of liver disease. Doctors prescribed medication to reduce the risk of the varices rupturing.

4. On 14 August, the man started antiviral treatment for hepatitis C as part of the national hepatitis early access programme. On 11 September, a liver consultant at hospital reviewed him and noted his liver function had deteriorated. The results of an MRI scan showed he was suffering from hepatocellular carcinoma (liver cancer).

5. The man’s condition was not suitable for active treatment and prison healthcare staff began an end of life care plan to ensure he received appropriate pain relief and support. On 27 October, his health deteriorated and was admitted to hospital. Two officers accompanied him to the hospital using handcuffs. An escort chain was used in hospital. Officers removed the restraints later that day, after a hospital consultant said their use was inappropriate. He remained in hospital until he died.

6. We agree with the clinical reviewer that the standard of healthcare the man received in prison was equivalent to that he could have expected in the community. However, the use of restraints when he went to hospital was not justified by a risk assessment that fully took into account his health at the time. We make one recommendation.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Lewes 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.

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

10. 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.

11. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin (another prisoner at Lewes) and one of his brothers (who lives in Australia). Both were concerned that his treatment programme for hepatitis C might have contributed to his death. His friend spoke highly of the care the prison gave the man and the way that prison staff had liaised with him before and after his death. The man's brother felt that the prison could have contacted him sooner and asked whether he had been prevented from contacting him in any way.

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 visits, liaison with his family, and whether compassionate release was considered.

13. The man's brother in Australia received a copy of the draft report. He pointed out some factual inaccuracies. This report has been amended accordingly.

14. The draft report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been added to the end of this report.

HMP LEWES

15. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 722 men, though the capacity was 729 at the time of the man's death. The Sussex Partnership NHS Foundation Trust Health provides health services, except GP and dentistry services. Custodial Medical Services Limited provides GP services. There is an inpatient unit with 12 beds, though there were 19 at the time of his death.

HM Inspectorate of Prisons

16. The most recent inspection of HMP 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

17. 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

18. The man's death is the fifth death at Lewes due to natural causes since 2012. We have raised the issue of the unjustified use of restraints before.

ISSUES

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

19. The man had a history of alcoholism and had hepatitis C. After he arrived at Lewes in February 2014, a doctor prescribed chlordiazepoxide to treat the symptoms of alcohol withdrawal and referred him to the prison's hepatitis clinic.

20. On 17 February, a hepatitis nurse specialist from the hospital reviewed the man. The results of a blood test showed an impaired liver function and the presence of hepatitis C antibodies. The nurse referred him for an ultrasound scan and an endoscopy. The ultrasound took place at the hospital on 17 March. The results showed he was suffering from liver cirrhosis and an enlarged liver and spleen.

21. The endoscopy on 20 June showed he was suffering from oesophageal varices and portal hypertension (both complications of liver disease). Doctors prescribed propranolol to reduce the risk of the varices rupturing. On 28 July, the man decided to stop taking this medication because it made him dizzy.

22. On 9 July, the clinical research clinic at the hospital contacted the prison about the man's hepatitis C treatment. A liver consultant at the hospital wanted him to start antiviral treatment. He had been put forward to receive treatment as part of the national hepatitis early access programme. Patients who are at a high risk of needing a liver transplant are eligible for this three year treatment plan. On 14 August, he started antiviral treatment (sofosbuvir, ledispavir and ribavarin) for hepatitis C as part of the early access programme.

23. On 1 September, the man collapsed in his cell. He was disorientated and confused, and nurses noted he was jaundiced. He went to hospital by emergency ambulance. On 3 September, he had a chest X-ray and ultrasound scan. Doctors noted a raised white blood cell count and signs of sepsis (a whole-body inflammation caused by an infection). He was given intravenous antibiotics for a possible chest infection. He returned to prison on 8 September.

24. On 11 September, the liver consultant saw the man for a routine assessment. Investigations showed deterioration in his liver function. The results of an MRI scan showed a mass in the right lobe of his liver which indicated a hepatocellular carcinoma (this is a primary cancer of the liver and often occurs when patients have underlying chronic liver disease and cirrhosis). The consultant explained the results to him the same day. The next day, the consultant informed prison GPs that the man had liver cancer.

25. We agree with the clinical reviewer that the man's alcohol withdrawal was appropriately managed and he was quickly referred for a hepatitis treatment programme. The ultrasound in March did not show any sign of a tumour and it was during a routine follow-up that the diagnosis of liver cancer was made.

The clinical reviewer was satisfied that his antiviral treatment did not contribute to his cancer, which happened to develop during his treatment. Hospital staff and healthcare staff at the prison kept him fully informed about his condition and treatment.

The man's clinical treatment

26. After his diagnosis, the man was referred to a hospital in London for further assessment. On 19 September, a prison GP prescribed morphine tablets as he was in pain.

27. On 9 October, the liver consultant told the man that no active treatment was possible and he was not suitable for a liver transplant. A prison GP referred him to the community palliative care team.

28. On 16 October, the man had a CT scan. The results showed that his condition was deteriorating. Healthcare staff began an end of life care plan to manage his pain relief and palliative care and nurses reviewed him daily. Doctors reviewed his pain relief and prescribed oramorph (liquid morphine) in addition to morphine tablets.

29. On 23 October, a hospital consultant informed the man at an outpatient's appointment, that he had only weeks to live. A Matron, the chaplain and a Listener (a prisoner trained by the Samaritans to give support and counselling to other prisoners) all spoke to him and offered support. A prison GP spoke to him the next day to discuss his condition.

30. On 27 October, the man's condition deteriorated. He was confused and restless but not fully conscious. A prison GP considered he could be suffering from hepatic encephalopathy, a brain condition caused by an accumulation of toxic substances normally removed by the liver. He was admitted to hospital for assessment.

31. The man remained in hospital and initially his condition improved. However, he quickly deteriorated and on 6 November hospital staff fitted him with a syringe driver to control his pain. (A syringe driver delivers a steady flow of pain relief at a constant rate.) His condition continued to deteriorate and a member of the hospital's palliative care team ensured his pain management was appropriate. During the night leading up to his death nurses checked him every hour. A nurse was with him when he died.

32. The post-mortem report showed the cause of death as pneumonia, hepatocellular carcinoma (liver cancer) and hepatitis C infection.

33. We agree with the clinical reviewer that the man received a good standard of end of life care which was at least equivalent to that he could have expected to receive in the community. He was able to attend hospital appointments, communication was good between the hospital and prison healthcare staff, who regularly monitored his condition and controlled his pain. Care plans

were in place and both hospital and prison staff kept him fully informed of his condition.

The man's location

34. Until he became seriously ill, the man lived in a single cell on standard prison wing. On 9 October, a prison GP recorded that he wanted him to move to a disabled cell in the healthcare unit, but he refused. On 15 October, a nurse advised him he should move to the inpatient unit for observation, but again he said he wanted to remain on L wing. On 17 October, he agreed to move to the inpatient unit when his health deteriorated further.

35. On 27 October, the man was admitted to hospital. On 5 November, he agreed to go to a hospice in Lewes. However, after his health deteriorated further, hospital staff decided it was not appropriate for him to move. We are satisfied that his location was appropriate throughout his illness.

Restraints, security and escorts

36. 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 judgement 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 judgement 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.

37. When the man went to hospital on 27 October, a security risk assessment considered that he was a low risk of escape and a low risk to hospital staff and the public. There was no history of escape or violence recorded. The healthcare section said that he required medical treatment due to liver failure and a doctor might need to examine all parts of his body. The risk assessment did not record any objection to the use of restraints but did not comment on how his condition affected his risk of escape as the court judgement require. Two officers escorted him and used handcuffs for the journey to hospital and then an escort chain in hospital. (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.)

38. At 4.25pm, a hospital consultant told the escorting officers that the use of restraints was not appropriate due to the man's serious medical condition. The duty governor gave permission for the restraints to be removed shortly after.

39. 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. The escort assessment showed all the man's risks as low and he did not pose any risk of escape. We note that he had been an inpatient at the prison from 17 October, as he was too unwell to live on the wing. The risk assessment did not consider how his state of health at the time he left the prison impacted on his risk of escape, a requirement of the 2007 High Court judgement. We have raised this issue before with the prison, who accepted the recommendation and undertook to ensure this was done. However, in this and another recent case, we have found that the prisoner's condition was not fully taken into account. His restraints were removed only after a hospital consultant objected to their use. 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

40. After the man's diagnosis, his friend, his nominated next of kin, visited him daily, including when he was in the inpatient unit. When he was taken to hospital on 27 October, a member of the chaplaincy told his friend and the chaplaincy and healthcare staff kept him informed of his condition.

41. On 28 October, the prison appointed two officers as family liaison officers. Records show that the man had two brothers, both living abroad, one in Greece and one in Australia. The records show that one family liaison officer contacted the brother who lived in Greece, as it appeared that the man was not in contact with his brother in Australia. His brother, who lives in Australia, does not believe that this contact took place but we are unable to ascertain which account is correct. His brother also told us they were in regular contact.

42. On 12 November, a family liaison officer arranged for the Greek Orthodox chaplain and the man's friend to visit him at the hospital.

43. After the man's death, the Greek Orthodox chaplain told his friend. The records show he also telephoned the man's brother in Greece. The funeral was held on 25 November and his friend attended. The prison contributed to the funeral costs in line with national guidance.

44. The man's other brother, who lived in Australia, was concerned that the prison did not inform him when his brother became ill. However, we are satisfied that the prison liaised appropriately with the listed next of kin. In addition the prison informed a family member when he was admitted to hospital. There is no indication that the man had asked the prison to inform anyone else when he became ill and he was not prevented from contacting his family in any way.

Compassionate release

45. Prisoners can be released on compassionate grounds for medical reasons before their sentence has expired. This is usually when they are suffering from a terminal illness, have a life expectancy of less than three months and meet a range of other criteria.

46. On 23 October, the prison's probation manager started the application for release on compassionate grounds. Reports to support the application were provided by the liver consultant and a prison GP.

47. On 24 October, the man told a prison GP he did not have any family and preferred to spend the end of his life in prison with people that he knew. The GP reassured him he would only be released if a suitable location was found.

48. On 7 November, a consultant in palliative medicine provided a report in support of the application. She said the man's end of life care could not be provided in the prison and he should be moved to a hospice.

49. When the man's condition deteriorated hospital consultants decided he was unable to move from the hospital. The application for release on compassionate grounds was not considered further. We are satisfied that the prison appropriately considered compassionate release.

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.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	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.	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 Head of Equalities and Safer Custody & Head of Security and Operations