PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in October 2013 while in the custody of HMP Long Lartin

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 lung cancer, at the Alexandra Hospital, Redditch, on 20 October 2013, while in the custody of HMP Long Lartin. He was 65 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Long Lartin. The prison cooperated fully with the investigation.

The man was sentenced to 17 years in prison in 2009 and moved to Long Lartin in July that year. He had multiple chronic conditions including chronic obstructive pulmonary disease (COPD) and asthma. Healthcare staff reviewed him frequently. In February 2013, the man began to complain of a dry cough and hoarseness. Despite treatment over the following months he did not improve. On 2 October, the man was admitted to hospital but his condition continued to deteriorate and he died in hospital nearly three weeks later. It was not until after his death that it was discovered he had been suffering from lung cancer.

The clinical reviewer concluded that the man received a good standard of healthcare at Long Lartin and the sudden deterioration in his health could not have been predicted or his death prevented. However, I am concerned that too much emphasis on security resulted in the man being unnecessarily restrained in hospital until shortly before his death and that his family was not informed that he was seriously ill in hospital until a very late stage.

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 **June 2014**
Prisons and Probation Ombudsman

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SUMMARY

1. The man was sentenced to 17 years in prison in 2009 and moved to HMP Long Lartin in July the same year. He was diagnosed with several medical conditions including asthma, diabetes and chronic obstructive pulmonary disease (COPD encompasses a number of lung diseases including chronic bronchitis and emphysema).

2. In February 2013, the man had a chest X-ray after reporting a persistent dry cough. The results showed that the man's lungs were normal. Over the coming months he continued to receive treatment for his other medical conditions.

3. In September, the man complained that his voice was hoarse and a doctor prescribed a salbutamol nebuliser (which opens up the air passages in the lungs) and oral steroids to improve asthma symptoms. The doctor diagnosed a chest infection on 25 September and moved the man to the prison's inpatient unit for observation.

4. On 27 September, the man was admitted to the Alexandra Hospital, Redditch, as his symptoms had not improved. He was discharged the following day with a recommendation that he should be referred to the hospital Ear, Nose and Throat department if his condition did not improve. On 1 October, a prison doctor made an urgent referral for the man to be seen within two weeks for suspected cancer.

5. The man was admitted to hospital on 2 October when his condition deteriorated. The man did not respond to treatment and he died in hospital on 20 October, before a firm diagnosis had been made. A post-mortem established his cause of death was lung cancer.

6. The clinical reviewer was satisfied that the man received a good standard of healthcare while he was at Long Lartin. He noted that the man's health problems were chronic and complex and his death could not have been prevented.

7. Although the man was assessed as a low risk of escape, restraints were used when he was in hospital and we are not satisfied that the risk assessment fully took into account his state of health and mobility. We are also concerned that the man's family was not informed when he was first admitted to hospital.

THE INVESTIGATION PROCESS

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

9. The investigator visited Long Lartin on 30 October and obtained copies of the man's relevant prison and prison medical records. She visited the wing and the inpatient unit where the man had lived and spoke to the Head of Healthcare and the prison's family liaison officer. She met the Acting Governor and a member of the local Independent Monitoring Board. On 29 November, the investigator interviewed three members of staff at Long Lartin. She gave the Governor initial verbal feedback and followed this up in writing.

10. NHS England appointed a clinical reviewer to review of the man's clinical care at the prison.

11. The investigator informed HM Coroner for Worcester of the investigation and the Coroner provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers wrote to the man's stepdaughter, his nominated next of kin, to explain the purpose of the investigation. The man's stepdaughter said she had not been informed when he was admitted to hospital and had telephoned the prison a number of times while he was in hospital and had been told that he was fine. She said it was not until he was critically ill on 19 October that the prison told her he was in hospital.

13. The family liaison officer also spoke to the man's daughter who had not been in contact with him and had been unaware that he had been ill. His daughter was not happy with the communication from the prison which meant that she had been given only one day's notice of the funeral.

14. The man's family received a copy of the draft report. They did not make any comments.

HMP LONG LARTIN

15. HMP Long Lartin is a high security prison holding category A and B adult men who have been sentenced to at least four years imprisonment. NHS Worcestershire is the healthcare provider. There is a small acute admissions unit for prisoners needing more intensive care.

HM Inspectorate of Prisons

16. The most recent inspection of Long Lartin in August 2011 concluded that healthcare was good and well organised. The Inspectorate noted that the healthcare inpatient unit provided a good standard of care. The scope of primary care services was impressive and included minor surgery, and the range of clinics included those for the care of age-specific and lifelong conditions. Inspectors found that the appointments system had improved, clinics were well managed and waiting times were short.

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. It its most recently published annual report for the year 2012/13 the IMB noted that the healthcare department was coming to an end of an extensive programme of updating and refurbishment. The IMB reported a high attendance of prisoners at the doctor's daily surgeries and the queues at dispensaries were long but carefully supervised.

Previous deaths at Long Lartin

18. Since 2012 there have been six deaths at Long Lartin. In two of the previous cases we have raised the issue of the inappropriate use of restraints.

KEY EVENTS

19. The man was sentenced to 17 years in prison in 2009 for sexual offences. He moved to HMP Long Lartin on 24 July 2009 from Wormwood Scrubs. Before his imprisonment he had been diagnosed with high blood pressure, asthma and COPD for which he took a variety of medications, including a salbutamol inhaler. The man told healthcare staff he smoked and was advised about giving up.

20. The prison obtained a summary of his medical records from his community GP on 17 August 2009. Over the next three years the man's conditions were managed well. He had frequent appointments with healthcare staff and appropriate tests and referrals.

21. On 23 November 2012, the man said he wanted to stop smoking and a prison doctor prescribed nicotine replacement patches. However, the man started smoking again a few months later.

22. On 22 January 2013, a prison GP referred the man for a chest X-ray because he was suffering from a persistent dry cough and oral thrush. The X-ray on 11 February showed that the man's lungs were clear.

23. The man continued to receive treatment for his other medical conditions. At an asthma review on 20 June he told the nurse that he was taking salbutamol daily and was not willing to give up smoking.

24. On 10 September, another prison GP examined the man who said he had a dry throat. The man said he had stopped smoking a few weeks earlier and now felt like he needed to cough something up but was unable to do so. The GP noted that the man's throat was normal and his chest clear. He suggested that the man should try steam inhalation to relieve his symptoms.

25. On 18 September a prison nurse saw the man who said he was having difficulty coughing and that his voice was hoarse. The man described waking at night feeling like he had to fight for breath. The nurse referred the man for an appointment with the doctor.

26. A GP saw the man on 20 September and found that his chest was clear. She suspected that his symptoms were due to asthma and prescribed a salbutamol nebuliser to be used twice a day and oral steroids. The next day, a nurse admitted the man to the inpatient unit for observation. He was given a nebuliser and the levels of oxygen in his blood were monitored. The man returned to his wing on 22 September.

27. On 25 September, the GP examined the man because his condition had not improved. She increased his nebuliser usage to four times a day. She suspected a chest infection and prescribed a course of antibiotics. The man was admitted to the inpatient unit and it was planned that the doctor would review him each day.

28. The GP sent the man to the Alexandra Hospital, Redditch, on 27 September, because he was not responding to treatment. In hospital a chest X-ray was clear. The man was treated for an upper respiratory tract infection and returned to the prison's inpatient unit on 28 September. The hospital advised that the man should be referred to an Ear, Nose and Throat (ENT) specialist if he did not show signs of improvement.

29. On 1 October, a prison GP, examined the man and noted that his chest was clear. However the hoarseness in his voice had not improved so the GP made an urgent two week referral for suspected cancer, to an Ear, Nose and Throat (ENT) consultant.

30. The next day, 2 October, the GP was concerned about his abnormal blood test results and his failure to respond to treatment and the man was taken to hospital as an emergency.

31. A risk assessment was carried out before the man was taken to hospital to assess the level of security were required. The man was assessed as a low risk of escape and risk to hospital staff but a high risk to children and medium risk to the public. The healthcare section of the risk assessment was not completed.

32. The risk assessment concluded that three officers should accompany the man and he should be double cuffed for the journey. (This means the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) An escort chain (a long chain with a handcuff at each end) was to be used when the man was in a hospital bed. During treatment the escort chain was to be used with standard handcuffs. It was written on the risk assessment that the man's family should not be told that he had been taken to hospital.

33. The man was treated with oxygen therapy, intravenous fluids and antibiotics in hospital. Healthcare staff from the prison kept in contact with the hospital for information about the man's condition. Hospital staff said that despite receiving treatment, the man had not shown any significant signs of improvement. It was noted that the man needed assistance to get to the bathroom and spent most of the day asleep. On 17 October, the prison's clinical team manager was told that the man had attended the ENT department for investigation into his hoarse voice and difficulty with swallowing. The man's weight had reduced from 75kg on admission to 67.4kg.

34. On the morning of 19 October, a senior hospital registrar said that the man's condition had deteriorated and he was likely to die within the next 24 hours. He had not received a diagnosis for his condition at this time. The prison's family liaison officer contacted the man's stepdaughter at 11.16am and informed her that he was seriously ill. The deputy governor visited the man at 11.30am that day and decided that his restraints should be removed. His stepdaughter visited the hospital later that day and remained with him overnight until he died at approximately 8.00am on 20 October.

35. Prisoners and staff were informed of the man's death and prayers were said in the prison chapel. A debrief was held on 20 October and staff were offered support from the care team. The man's funeral took place on 8 November and Long Lartin contributed to the costs in line with national guidance.

Post-mortem

36. A post-mortem examination on 25 October found that the cause of death was carcinoma of the left lung.

ISSUES

Clinical care

37. The clinical reviewer commented that the man suffered from a number of serious chronic illnesses for which he received appropriate treatment. The man had frequent appointments with healthcare staff to manage his respiratory conditions and specialist asthma nurses reviewed him regularly. In January 2013, the man complained of a persistent dry cough and was referred for a chest X-ray. The clinical reviewer considered that in view of the normal chest X-ray result and the lack of respiratory symptoms before September 2013, the man's condition could not have been detected any earlier.

38. The clinical reviewer concluded that the man was appropriately referred to hospital twice when it became clear he was not improving. He considered the man received a satisfactory standard of care during his time at Long Lartin. His medical problems were chronic and complex and his final illness and deterioration rapid. The clinical reviewer described the man's death as unavoidable. We are therefore satisfied that there is nothing the prison could have done to prevent his death.

Restraints, security and escorts

39. The man was a Category B prisoner regarded as a low risk of escape and risk to hospital staff. He was assessed as a high risk to children and medium risk to the public if he escaped.

40. The Prison Service has a duty to protect the public when escorting prisoners 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. 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 deemed that handcuffing 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. The risk assessment must be kept under review to take account of the prisoner's changing clinical condition, treatment being received and any input from healthcare staff.

41. The original risk assessment did not include any medical opinion about whether the man's poor health would affect any risk of escape as the court judgement requires. The man was 65 years old, required assistance to use

the bathroom, was receiving oxygen therapy and his condition had deteriorated significantly during his time in prison and later in hospital. We are not satisfied that the risk assessment fully justified the use of double cuffing to take a sick man to hospital, particularly as he was escorted by three officers.

42. The man's risk assessments were reviewed during his time in hospital but there is no evidence that his health was considered and no record of any consultation with medical staff about how his condition affected his mobility and risk of escape. The man's remained restrained until 19 October when he was given just 24 hours to live. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including how their health and mobility impacts on their risk of escape, and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

43. PSI 64/2011 Safer Custody requires:

> *"Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner, engaging with their next of kin or nominated person and providing support for staff."*

44. As well as the procedures in PSI 64/2011 – Prison Rule 22(1) states:

> 'Notification of illness or death
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> '22 – (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

45. When a seriously ill prisoner is taken to hospital, his next of kin should be informed as soon as possible. We consider that when the man was admitted to hospital as an emergency on 2 October, he should have been regarded as seriously ill and his family contacted at that stage. It is concerning that the man's stepdaughter, his nominated next of kin, was not informed he was in hospital until 11.16am on 19 October 2013 when he was very near death. This allowed very little opportunity to visit and spend some time with him before his death. It is unacceptable that when she rang the prison to enquire about his health, unaware that he had been taken to hospital, his stepdaughter was not told that there were any concerns.

46. On 25 November, the Acting Governor wrote to the man's stepdaughter and apologised for not informing her of the man's admission to hospital until the day before he died. The Acting Governor explained that the prison's local

procedures had been reviewed after the man's death, to ensure that all staff are aware of the actions necessary when a prisoner is in hospital. We are concerned that these procedures still would not normally allow families to visit until the prisoner had been in hospital for 72 hours. This is inappropriate for someone who is seriously ill. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without delay.

47. The man had a daughter who had not been in touch with him and was unhappy that she had not been informed of her father's death by the prison and had not been told about his funeral until just the day before. She had other concerns about his offence and sentence management which are not matters for the PPO to consider and which we have passed to the prison to respond. We understand that the prison had no information about his daughter or any contact details until the Coroner provided this information after his death. It is regrettable that this meant that his daughter was not informed until a late stage. We would have expected the prison to have received this information through the man's offender manager (probation officer) but we are satisfied that the prison contacted his daughter when they were able to do so.

RECOMMENDATIONS

1. The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including how their health and mobility impacts on their risk of escape, and are based on the actual risk the prisoner presents at the time.

2. The Governor should ensure, in line with Prison Rule 22 that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without delay.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that risk assessments for prisoners in hospital fully take into account individual circumstances, including how their health and mobility impacts on their risk of escape, and are based on the actual risk the prisoner presents at the time.	Accepted	***Risk assessments now detail that consideration must be given to the appropriateness of cuffs for prisoners suffering ill health.*** ***Management checks on bedwatch documentation now require the visiting manager to comment on whether or not cuffs remain appropriate.*** ***Bedwatch escorts that have been out for 14 days will have the risk assessment reviewed every 7 days as a matter of routine and immediately any new diagnosis is made.*** ***Healthcare risk assessments will be amended to include medical opinion on a prisoners health and if it impacts on risk of escape.***	Completed Head of Operations 31 March 2014 Head of Healthcare	
2	The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital	Accepted	***A Notice to Staff has been issued which reminds all staff about Prison Rule 22, and the death in custody policy will be re-written to include this.***	***31 March 2014 Head of Safer Custody***	

	without delay.				