Independent investigation report by the Prisons and Probation Ombudsman Nigel Newcomen CBE into the death of a man, a prisoner at HMP Northumberland, in February 2015.

Our Vision

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

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 such as this 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.

The man died of a gastrointestinal haemorrhage and oesophageal cancer in February 2015, while a prisoner at Northumberland. He was 63 years old. I offer my condolences to his family and friends.

The clinical reviewer found that nurses at Northumberland were supportive and caring. Although there were some delays by the hospital in confirming the man's diagnosis, the clinical reviewer considered this should not have prevented prison healthcare staff from holding multidisciplinary meetings to review his care and ensure his pain management was effective, when it appeared he had cancer. The lack of 24-hour nursing cover made it more difficult to manage his symptoms effectively, but he did not want to move to another prison for inpatient care and the prison honoured his wishes.

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 **September 2015**

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SUMMARY

Events

1. The man was sentenced to an indeterminate sentence for public protection in May 2007. He had been at HMP Northumberland since May 2008.

2. At the end of November 2014, a GP examined the man, who reported that he had lost weight and was constipated. The GP decided to monitor him. He continued to feel unwell and blood tests indicated some abnormalities. In December, the GP referred him for a routine chest X-ray. As he had been reporting vomiting, constipation and indigestion for some time, a GP made an urgent referral on 12 January, for suspected bowel cancer. The results of these investigations were clear.

3. On 15 January, the results of the chest X-ray showed a mass lesion in the man's lung and the next day, a prison GP made a further urgent referral to hospital specialists for suspected lung cancer and asked for a CT scan of his head, chest and abdomen. On 10 February 2015, test results confirmed he had cancer of the gullet. On 11 February, he was admitted to hospital with abdominal pain. He had internal bleeding and was given a blood transfusion. On 12 February, hospital staff moved him to their palliative care unit for end of life care. He died a few days later.

Findings

4. The clinical reviewer noted that healthcare staff implemented care plans to manage the man's symptoms, but did not hold a multidisciplinary meeting to review his care plans, ongoing investigations and pain management as he did not have a diagnosis. As it was likely he had cancer, the clinical reviewer considered that the lack of a formal diagnosis should not have prevented this. She commended staff for the good level of emotional support and care they gave him, but noted that the absence of 24-hour nursing cover made the observation of his variable condition and effective symptom control difficult. We are concerned that this meant that he did not always have appropriate access to pain relief at night, but recognise that he had refused to move to HMP Holme House, which has 24-hour healthcare.

Recommendation

- The Head of Healthcare should ensure that seriously ill prisoners have access to appropriate levels of pain relief at all times.

THE INVESTIGATION PROCESS

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

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

8. The investigator obtained copies of relevant extracts from the man's prison and medical records. The clinical reviewer interviewed four members of healthcare staff at HMP Northumberland on 31 March. On 16 April, the investigator interviewed three members of prison staff by telephone.

9. We informed HM Coroner for North Northumberland of the investigation who sent the results of the post-mortem examination. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers wrote to the man's brother, his next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We have not received a response.

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

12. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

BACKGROUND INFORMATION

HMP Northumberland

13. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison can hold more than 1,300 men. Sodexo Justice Services has managed the prison since 1 December 2013. Until April 2015, Care UK provided healthcare services. G4S is now the healthcare provider. There are no inpatient facilities.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of Northumberland was in September 2014. The report was critical of many aspects of the prison but found that the quality of healthcare was generally good and appreciated by prisoners. There was an appropriate range of clinics to meet prisoners' needs but inspectors noted that care-planning involving a range of professionals for prisoners with complex care needs was underdeveloped. Inspectors considered that there were appropriate palliative care arrangements.

Independent Monitoring Board

15. Each prison 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 year to December 2014, the IMB noted that health services were good overall and they were broadly satisfied that the healthcare and mental health responsibilities at the prison were met.

Previous deaths at HMP Northumberland

16. The man was the seventh prisoner to die from natural causes at HMP Northumberland since January 2014. We have raised the issue of the need for properly considered risk assessments for the use of restraints before.

FINDINGS

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

17. The man was serving an indeterminate prison sentence and had been at HMP Northumberland since May 2008. He had a history of chronic drug and alcohol addiction, was a long-term cigarette smoker and received regular pain relief for neck pain. He had little significant interaction with healthcare staff until November 2014.

18. On the 25 November 2014, a prison GP examined the man, who complained of constipation and weight loss. He had lost 15kg in weight in two years and the GP planned to monitor his weight fortnightly. He prescribed a laxative.

19. On 4 December, the man told a nurse that he had vomited the previous night and felt generally unwell. He said that he had been suffering from abdominal pain for two weeks but he was no longer constipated. The nurse arranged routine blood tests, which showed some abnormalities. On 9 December, a GP examined him and noted he had a slight cough but his chest was clear and there were no abdominal masses. He referred him for a routine chest X-ray because of the abnormal blood results, unintentional weight loss and because he was a long-term smoker.

20. On 30 December, a nurse weighed the man and recorded he had lost a further 6kg and said he was constipated. She noted he was due for an X-ray on 7 January and arranged for someone to weigh him each day.

21. On 6 January 2015, the man told a nurse that he had abdominal pain, had vomited and had not opened his bowels for six days. The nurse discussed this with a GP, who increased his dose of laxative and prescribed paracetamol for the pain.

22. On 7 January, the man had a chest X-ray at the prison, which was sent to hospital for analysis. On 10 January, a nurse saw him in his cell; he had vomited and reported diarrhoea but said there were no signs of blood. The nurse noted his abdomen was not distended and requested hourly observations. The next day a nurse saw him, who was worried about his health, and listed him to see the GP the next day.

23. On 12 January, a prison GP saw the man and was concerned about his weight loss and the change in his bowel habit so made an urgent referral to the colorectal team at the hospital under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. She explained the reason for the referral to him and healthcare and wing staff gave him emotional support.

24. On 15 January, the prison received the chest X-ray results, which showed a mass lesion. The report said this was consistent with probable bronchial

neoplasm (a form of lung cancer) or lymphadenopathy (enlarged lymph nodes).

25. On the 16 January, a prison GP made an urgent referral to the respiratory team at the hospital for probable lung cancer and asked for an urgent CT scan of the man's head, chest and abdomen.

26. On 19 January, the man attended the hospital colorectal clinic for suspected bowel cancer. A consultant examined him and found nothing abnormal.

27. On 24 January, the man had increasing and uncontrolled pain and a doctor prescribed codeine (a strong painkiller) in addition to paracetamol. On 28 January, he went to hospital for a CT scan of his chest, abdomen and pelvis.

28. On 30 January, a prison GP saw the man, who had been vomiting and complaining of abdominal pain. She discussed his condition with a consultant at the hospital, who advised that he needed a gastroscopy (a camera to look between the throat and stomach) which would need to be carried out at another hospital. He went to the hospital for the procedure the same day and returned to the prison on 3 February.

29. On 10 February, the prison received the results of the CT scan, which confirmed the man had cancer, although the source was not clear. There is no record that anyone discussed this with him that day.

30. At 11.30pm on 10 February, the man reported severe abdominal pain. The on-call GP advised that he could take some paracetamol and codeine and wait to see the GP in the morning, or go to hospital for a review of his pain relief. His pain became worse during the night and he was taken to hospital by taxi at 3.45am on 11 February.

31. The hospital admitted the man and later that morning, a hospital consultant examined him. He informed him that he had cancer, but needed more investigations to determine the source.

32. While it appears it took longer than usual for the hospital to send the chest X-ray result, which delayed the man's urgent referral to a respiratory specialist, the clinical reviewer noted that this would not have affected the outcome for him. We are satisfied that prison GPs referred him appropriately for tests for suspected cancer when his symptoms indicated. He was aware that it was likely that he had cancer and staff gave him support. Unfortunately, there was no time to tell him when his formal diagnosis was received on 10 February, but a hospital doctor informed him the next day.

The man's clinical care

33. Although the prison did not receive a formal diagnosis for the man until 10 February, healthcare staff strongly suspected that he had cancer and implemented care plans to manage his symptoms. On 22 January, a nurse added him to the prison's palliative care register and noted his uncertain diagnosis and pending investigations. The palliative care register is a way of tracking a patient's progress, assessing physical and emotional needs and generates care plans and referrals for specialist palliative care. She said that she had begun the process because of the chest X-ray findings and the likely diagnosis of cancer.

34. The clinical reviewer noted that there were no multi-disciplinary meetings at Northumberland to discuss the man's probable diagnosis and symptom management. Although there were care plans to manage his symptoms, there is no evidence that anyone reviewed his pain management or followed up the test results. She was concerned that it had been necessary to take him to hospital in the early hours of 11 February, to manage his pain relief.

35. The clinical reviewer considered that, when a prisoner has suspected cancer and a range of symptoms which are difficult to control, there should be regular, multi-disciplinary meetings to support the implementation of care plans. She commended staff for the good level of emotional support and care they gave the man, but noted that the absence of 24-hour nursing cover made the observation of his variable condition and effective symptom control difficult. (He had declined a move to Holme House, which has 24-hour nursing cover.)

36. At 7.25pm on 11 February, after the man had been admitted to hospital, his condition deteriorated, he became semi-conscious and had internal bleeding. Hospital staff described his condition as critical and gave him a blood transfusion. On 12 February, he was transferred to the palliative care suite in the hospital. His condition continued to decline and he died a few days later.

37. A post-mortem showed that the man died from a gastrointestinal haemorrhage (severe bleed in the stomach) and oesophageal carcinoma (cancer of the gullet).

38. We are satisfied that overall, the man received some good supportive care at Northumberland but note this would have been improved by multidisciplinary reviews of his care. The clinical reviewer has made a recommendation about this, which the Head of Healthcare will need to address. We are concerned that this meant that he did not have appropriate pain relief on the night of 10/11 February. We make the following recommendation:

    The Head of Healthcare should ensure that seriously ill prisoners have access to appropriate levels of pain relief at all times.

The man's location

39. In January, staff moved the man from a standard cell to a ground floor cell with a shower, adapted for prisoners with disabilities. He had a high backed chair and cushion and access to a wheelchair and a care orderly to take him to healthcare appointments.

40. The clinical reviewer considered that the effective management of the man's symptoms was hindered by the absence of an inpatient facility, which meant he had no access to nursing care at night. However, the Head of Healthcare told us that they had arranged to move him to Holme House in November, but he had refused to go. He wanted to stay at Northumberland with his friends. The prison had therefore allowed him to stay at Northumberland for as long as possible. In February, arrangements were underway to move him to Holme House, but he was admitted to hospital before this could happen. We are satisfied that the prison appropriately considered his preferences about his location.

Restraints, security and escorts

41. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

42. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

43. The man went to hospital four times in January. Each time he was escorted by two officers and handcuffed. On 30 January, he was admitted to hospital and the handcuffs were replaced with 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). The prison has not provided the escort risk assessments for these visits, so we have been unable to assess whether his risk at the time was appropriately considered or whether there was any healthcare input into the risk assessments. The security manager told us that two escorts using single handcuffs is the standard procedure at the prison.

44. When the man was taken to hospital in the early hours of 11 February, he was escorted by two officers and handcuffed for the journey and an escort chain was used in hospital. There was no healthcare input into his risk assessment at the time, as no healthcare staff were on duty. At 7.25pm on 11 February, his condition became critical and he needed a blood transfusion. Officers removed the escort chain which was not used again.

45. The manager told us that when prisoners need to go to hospital, the aim is to get prisoners there as quickly as possible and reasses the situation with the aim of removing restraints as soon as possible, if appropriate. We accept that, as the man was taken to hospital in the early hours of the morning, it would have been difficult to carry out a full risk assessment, with healthcare input at the time. Although there appears to have been a risk assessment later that day, the healthcare input consisted of just two ticked boxes, which indicated there was no medical objection to restaints and that his condition did not impact on his risk of escape. This is insufficient information. As we have recently made a recommendation to the prison about the need for fully informed risk assessments which the prison will need to implement, we do not repeat it here. We recognise that officers removed his restraints later on 11 February and did not reapply them,

Liaison with the man's family

46. On 23 January, the prison appointed a family liaison officer because of the man's likely cancer diagnosis. The officer saw him the same day, who said he had support from his family and was in touch with them, but would like help sorting out his personal affairs. The officer saw him a number of times to support him and help him with his personal affairs.

47. At 10.10pm on 11 February, the family liaison officer telephoned the man's brother, who he had named as his next of kin, to let him know that his brother's condition was deteriorating. He also contacted the man's niece the next morning. He arranged for the family to visit him in hospital, met them at the hospital later that day, and offered them support. After the man died, the officer went to the hospital to support his family.

48. The funeral was on 25 March and the prison contributed to funeral costs in line with national guidance.

49. We are satisfied that there was good liaison with the man's family about his illness.

Compassionate release

50. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. The man made it clear that he did not want to apply for compassionate release.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that seriously ill prisoners have access to appropriate levels of pain relief at all times.	Accepted	We will ensure that seriously ill prisoners have access to appropriate pain relief at all times, convening multi-disciplinary team meetings to support the implementation of the care plan whenever necessary. If it becomes impossible to provide appropriate care for a prisoner at HMP Northumberland, a transfer to a prison with 24 hour healthcare will be arranged as soon as possible.	Head of Healthcare Completed August 2015	