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 November 2014 a prisoner at HMP Northumberland

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 colon cancer in November 2014, while a prisoner at HMP Northumberland. He was 43 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Northumberland was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to nine years imprisonment in September 2012. In February 2014, he began to experience bouts of constipation and unexplained abdominal pain. Prison doctors referred him to hospital a number of times for investigations, but doctors did not diagnose cancer until 29 October, eight months after his symptoms first appeared and several days before he died. By then, the cancer was too advanced to treat.

The investigation found that healthcare staff at HMP Northumberland missed some opportunities that might have led to the man's cancer being diagnosed earlier, when he reported persistent symptoms. However, the clinical reviewer noted that he had other health conditions, which made it more difficult to recognise the significance of some of his symptoms, and considered that his overall care was equivalent to that he would have expected to receive in the community. I am concerned that the use of restraints when he went to hospital was not justified by appropriately considered risk assessments, a matter I have raised with the prison before.

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. The man was serving a nine year sentence for rape and witness intimidation, and had been at HMP Northumberland since 11 September 2012. In February 2014, he complained of constipation and abdominal pain. Healthcare staff prescribed laxatives, with little effect. His clinical observations were normal.

2. On 5 March, after the man reported that he had been vomiting solids, a prison GP diagnosed a viral infection. He later complained of melaena (black, tarry faeces that are associated to gastrointestinal bleeding). The GP requested a chest X-ray, ultrasound and blood tests.

3. On 18 March, blood tests indicated the man had hepatitis C. Two days later, an ultrasound scan of his abdomen showed his liver, pancreas, kidneys and spleen were normal and did not find any tumours. A chest X-ray, the same day, showed that his lungs were clear and his heart was of normal size. A prison doctor later told him that his symptoms were related to hepatitis.

4. The man was admitted to hospital twice in April, for surgery to stitch a bleeding ulcer and an artery in his abdomen. Hospital doctors diagnosed probable helicobacter pylori, a bacterial infection causing ulcers, abdominal pain, weight loss, and vomiting. From mid-May, he reported rectal bleeding and changes in his bowel habits, which persisted over a number of weeks. Prison doctors did not refer him urgently to a specialist for suspected cancer, which was a possibility.

5. Endoscopies of the man's stomach on 22 July and 19 August found no further concerns. On 22 September, after he reported having chest pain, a prison GP diagnosed an upper respiratory tract infection. The doctor prescribed antibiotics and referred him for an ultrasound scan of his abdomen. On 10 October, he was admitted to hospital, with breathing difficulties. Hospital doctors later diagnosed pneumonia.

6. While in hospital, a CT scan of the man's chest and an endoscopy showed abnormalities. On 29 October, a hospital consultant informed him that he had colon cancer, which had spread to his lungs. His condition was terminal and only palliative care was possible. Prison and hospital staff planned to transfer him to HMP Holme House for end of life care. However, his condition deteriorated very quickly and he died in hospital, several days after his diagnosis and before the transfer could take place.

7. The clinical reviewer considers that, although there were some delays in referring the man for specialist assessment, this was understandable as some of his symptoms were also indicative of his other health conditions. Overall, he considered his care was broadly equivalent to that he could have expected to have received in the community. We are concerned that the use of restraints when he went to hospital was not fully justified. We make two recommendations.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records.

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

11. We informed HM Coroner for Tyne and Wear, North Tyneside District, of the investigation, who notified us of the cause of death. We have sent the coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's wife on 3 December 2014, to explain the investigation. She asked for further information on the following:

    - How her husband's treatment was managed from April 2014 onwards, which she considered had been poor. In particular, she wanted to know about his weight loss and a possible delay in diagnosing a bleeding ulcer.
    - The reason why he was given codeine when he was coughing up blood.
    - The actions taken to arrange his transfer to Holme House.

13. 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.

14. The draft 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.

15. The man's wife received a copy of the draft report. She did not make any comments.

HMP Northumberland

16. HMP Northumberland was formed in 2011 by the merger of two separate prisons, HMP Acklington and HMYOI Castington. The prison holds up to 1,300 sentenced men. Since 1 December 2013, Sodexo Justice Services has managed the prison. Care UK provides healthcare services. There are no inpatient facilities.

HM Inspectorate of Prisons

17. The most recent inspection of Northumberland was in September 2014. Inspectors found that health services were good overall, but external hospital appointments were often cancelled at short notice. Care planning involving a range of professionals for prisoners with complex care needs was underdeveloped and there was no lead clinician for these cases.

Independent Monitoring Board

18. 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. In its most recently published report for the year to December 2013, the IMB noted that in general it was satisfied that the prison met its responsibilities in relation to healthcare services. The IMB welcomed the use of mobile ultrasound and X-ray services, which increased prisoners' access to such provision.

Previous deaths at HMP Northumberland

19. The man was the third person at Northumberland to die from natural causes since 1 January 2013, and the second from cancer. There have been four further deaths since. We have made a previous recommendation about risk assessments for hospital escorts.

ISSUES

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

20. The man was convicted of rape in January 2012, and sentenced to nine years in prison in February. He transferred from HMP Holme House to HMP Northumberland on 11 September 2012. Health screens at Holme House had identified that he had a history of depression, substance misuse and mild asthma, but he was otherwise well. He smoked and did not want to stop. At a reception health screen at HMP Northumberland, a nurse noted that he had some concerns about his physical health, but she did not record what they were. He declined further assessment at a well-man monitoring clinic.

21. There were no further significant entries about the man's physical health in his medical record until 23 February 2014, when he reported having constipation. A nurse gave him senokot (a laxative) but his condition did not improve. Another nurse reviewed him on 27 February and noted that he had been constipated for one week. He said that he had been having pain under his navel and had been feeling sick and hot and cold. His clinical observations were normal. The nurse arranged for a GP to see him the next day.

22. A GP reviewed the man on 28 February and prescribed ispaghula husk, another laxative. He remained constipated and on 5 March, told a GP that he had upper abdominal pains and was vomiting solids. The GP suspected that he might have a viral infection and asked for blood tests.

23. On 9 March, a nurse examined the man, who said that he had lower back pain and had not been able to eat for days. A nurse noted that his partner had reported some concerns about his physical health.

24. The next day, a urine test detected high amounts of protein, a sign of possible infection or disease. On11 March, a GP examined the man and found that his liver was slightly enlarged but there were no growths or lumps. He was feverish, but had a good colour and was not jaundiced. The GP diagnosed a viral infection.

25. On 13 March, the GP reviewed the man, who complained of vomiting and melaena (black, tarry faeces that are associated with gastrointestinal bleeding). The GP noted continued weight loss and requested a chest X-ray, ultrasound and blood tests. On 17 March, the GP reviewed his blood test results, which showed his red blood cells count was marginally low (which can indicate anaemia). The results were classified as 'abnormal but expected'. The GP planned to review him after the results of the chest X-ray and ultrasound scan that had been arranged for later that week.

26. On 18 March, blood test results, taken two weeks earlier, were positive for hepatitis C. A nurse referred the man to the hepatology department at hospital for treatment.

27. On 20 March, an ultrasound scan of his abdomen showed the man's liver, pancreas, kidneys and spleen were normal. There was no evidence of a tumour in his abdomen. A chest X-ray showed that his lungs were clear and his heart was of normal size. The clinical reviewer commented that an ultrasound scan cannot visualise the digestive tract so a referral for an endoscopy should have been considered. (An endoscopy is an internal examination of the body, using a long thin flexible tube with a camera attached.)

28. The man continued to complain of abdominal pain. On 3 April, he told a GP that he was also experiencing night sweats. The GP explained that these were symptoms of hepatitis C and that he would try to chase up his hepatology referral.

29. On 6 April, wing staff found the man vomiting blood. Healthcare staff sent him to hospital by emergency ambulance. The prison informed his partner. The hospital performed a gastroscopy (where an endoscope is used to look inside the stomach) and surgery to stitch a bleeding gastric ulcer. The hospital prescribed codeine for post-operative pain, which the clinical reviewer considered was appropriate.

30. The clinical reviewer commented that prison healthcare staff had missed the signs and symptoms of a bleeding ulcer, which should have led to an urgent referral for specialist assessment and an endoscopy, in line with NICE (National Institute for Health and Care Excellence) guidelines. To a degree, the man's active hepatitis C infection had masked the symptoms, but this would not have explained the persistent melaena, which is indicative of an upper gastrointestinal bleed. However, the endoscope examination in hospital on 6 April found no evidence of cancer.

31. The hospital discharged the man on 15 April. A nurse reviewed him the next day and noted that he weighed 60 kilos and had lost four kilos since March. She noted that healthcare staff should weigh him weekly.

32. On 18 April, the man coughed up blood and was taken back to hospital as an emergency. In hospital, he had surgery on an artery in his abdomen. On 21 April, hospital doctors diagnosed probable helicobacter pylori, a bacterial infection causing ulcers, abdominal pain, weight loss, and vomiting; all symptoms he had previously suffered in prison. On 15 April, the hospital discharged him and advised that he should have another gastroscopy six weeks later (an examination of the stomach using an endoscope).

33. On 16 May, the man reported passing blood when he tried to open his bowels. During the next few weeks, he continued to report changes to his bowel movements, including frequent watery stools. Nurses recorded that he continued to lose weight and report severe pain and he was only able to walk short distances.

34. On 22 July, the man had a gastroscopy. This did not show any evidence of cancer and hospital staff did not identify any further concerns at the time.

35. On 6 August, the man reported that he had vomited during the night and a nurse noted that his stomach felt tight. He had gained weight and was now 64 kilos. A further gastroscopy on 19 August showed a healing ulcer and a tissue biopsy identified no concerns and no evidence of cancer. On 27 August, he said he could not eat a full meal and vomited after most meals. A GP reviewed him and prescribed a soft diet. His weight had reduced to 62 kilos.

36. On 18 September, a nurse, a specialist hepatitis nurse, reviewed the man and decided that they should delay treatment for hepatitis until his health improved. On 22 September, he told a GP that he felt pain all over his body, his constipation had returned and his chest hurt when he breathed in. The GP diagnosed an upper respiratory tract infection and prescribed antibiotics. He referred him for an ultrasound scan of his abdomen at a mobile scanner visiting the prison.

37. On 29 September, the man did not attend the healthcare centre for the ultrasound scan. No reason was recorded. On 3 October, he asked to see a doctor and a nurse noted that he had a non-productive cough, pain in his lower back and had not opened his bowels for seven days. The nurse spoke to the doctor and sent a further referral for an ultrasound scan of his abdomen.

38. The clinical reviewer noted that loss of weight and other symptoms such as chest pain, a non-productive cough, and shortness of breath could have been signs of lung cancer. The NICE Guidance suggests that an urgent referral for a chest X-ray should be offered when a patient presents these symptoms for more than three weeks. Although the man had had a clear X-ray in March 2014, as his symptoms had continued for over three weeks, further referrals would have been advisable in the following months.

39. On 10 October, the man told a nurse that he had breathing difficulties, felt anxious and dizzy. His blood oxygen levels were low at 89%. He had lost more weight and now weighed 58 kilos. A GP sent him to hospital for review.

40. Hospital doctors diagnosed pneumonia and treated the man with strong, intravenous antibiotics. On 13 October, an ultrasound scan of his abdomen showed that his gallbladder, liver and pancreas were normal. The next day, a CT scan showed some abnormalities and doctors referred him to the hospital's respiratory team. He continued to receive antibiotics and continuous oxygen, with little effect.

41. On 21 October, a gastroscopy showed abnormal tissue in the man's stomach. On the afternoon of 29 October, a hospital registrar asked prison escort staff to contact his family so that they could attend the hospital. A prison manager authorised his partner to visit. The same day, a doctor told him that he had colon cancer, which had spread to his lungs. On 30 October, a consultant explained to him that the cancer was terminal.

42. The clinical reviewer noted that healthcare staff at the prison missed some early signs, such as the change in bowel habits and rectal bleeding, which might have indicated colon cancer. He considers that healthcare staff should have referred the man for a colonoscopy when he reported the symptoms from mid-May. Although we cannot know whether earlier diagnosis would have altered the course of the disease, it would have enabled better care and treatment. However, the clinical reviewer considered that the presentation of signs and symptoms of colon cancer were complicated by his other health problems of active hepatitis C and a bleeding ulcer. These produce similar symptoms such as stomach pains, nausea, loss of appetite and tiredness, so it was easy to see how other symptoms could be missed. Nevertheless, best practice guidance is for healthcare professionals to be alert to the possibility of cancer when there are unusual symptom patterns or when patients thought not to have cancer do not recover as expected.

43. While we recognise that some of the man's other symptoms masked symptoms of cancer, we agree with the clinical reviewer that his symptoms should have led to urgent and appropriate investigation under the NHS pathway for suspected cancer. We make the following recommendation:

The Head of Healthcare should ensure that prison healthcare staff are familiar with National Institute for Health and Clinical Excellence (NICE) guidelines on the early diagnosis of cancer and that doctors refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.

The man's medical treatment

44. The man's healthcare after his diagnosis was solely provided by the hospital, which is outside the Ombudsman's remit. As his cancer was terminal, only palliative care could be provided. He decided that if his heart stopped or he stopped breathing, he did not want to be resuscitated.

45. Healthcare staff at the prison kept in close contact with the hospital and helped support the man and his family in his final days. This included immediate liaison with palliative care specialists.

46. The man died soon afterwards. No post-mortem examination took place as his hospital consultant confirmed the cause of death as colon cancer.

47. The clinical reviewer was satisfied that the man's care and treatment were in line with mainstream NHS practice, with the exception of the delays in referring him for specialist assessment identified above. He acknowledged that this was partly due to him having more than one medical disorder with similar symptoms. While not best practice, the clinical reviewer noted that such misinterpretation of symptoms could equally have occurred in any healthcare setting. For that reason, he concluded that his overall care was broadly equivalent to that he could have expected in the community.

The man's location

48. On 31 October, a nurse and a specialist palliative care nurse visited the man in hospital. The nurse discussed the possibility of a transfer to the palliative care suite at HMP Holme House, which was closer to his home. He was keen to transfer and this was planned for 3 November. By then, he was bedbound and receiving morphine to control his pain. On the morning of 3 November, the nurse explained to the specialist palliative care nurse that his condition had deteriorated rapidly and it would not be in his best interests to transfer to Holme House. He died at the hospital shortly afterwards.

49. We are satisfied that after the man's diagnosis, prison staff and others appropriately considered and agreed to his wish to a transfer to a prison nearer to his family home. Unfortunately, he was not well enough to move before he died.

Restraints, security and escorts

50. 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 which 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 the 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 prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

51. When the man was admitted to hospital as an emergency, on 6 April, prison managers completed an escort risk assessment which concluded he was a 'standard risk' to the public. The risk assessment contained no medical input about the use of restraints or his ability to escape in his current condition. Two prison officers escorted him and he was restrained with an escort chain. (An escort chain has a handcuff at each end, one attached to the prisoner and the other to an officer.) During his operation, and while sedated, he was not restrained. The escort chain was re-applied on 8 April.

52. On 12 April, the prison reviewed the risk assessment. Healthcare staff ticked a box on the form to indicate that in his current medical condition, the man had the ability to escape unaided, and there were no medical objections to the use of restraints. When he returned to hospital on 18 April, his prison escort risk assessment indicated that prison staff considered he was still a risk to the public. Healthcare staff indicated that there were no objections to the use of restraints. Two prison officers escorted him, using an escort chain.

53. When the man went to hospital for the last time, on 10 October, the prison escort risk assessment noted that he was a risk to the public and a single

handcuff should be used, with an escort chain if he was admitted for treatment. Prison managers did not ask healthcare staff whether there were any objections to restraints or how his condition at the time affected his risk of escape as the court judgment requires. The medical records indicate that at that point, he had breathing difficulties, had lost a significant amount of weight, was in considerable pain and his mobility was impaired. There is no record in the prison escort documents of whether his restraints were reduced to an escort chain once he was admitted to hospital. When the risk assessment was reviewed on 12 October, the officers were instructed to use an escort chain only. Again, there was no healthcare input. None of the risk assessments had an overall assessment of risk.

54. The man remained restrained in hospital until 3.55pm on 29 October, when the prison's duty manager instructed the escort staff to remove his escort chain. The escort was reduced to one officer the next day.

55. The risk assessment tool used by Northumberland only has a tick a box to indicate whether there is a risk. There is no provision to note the level of risk (e.g. low, medium, or high) of escape or to the public and, it does not record a full picture of the risk to enable an informed decision on the restraints necessary, according to the prisoner's current risk. There is no provision for appropriate healthcare input in line with the court judgment, to inform the overall assessment.

56. 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 are not satisfied that staff took sufficient account of the man's physical health in assessing his risk, as the court judgment requires.

57. Ultimately, it is the Director's responsibility to ensure that the risk assessment process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility affects the risk of escape. We make the following recommendation:

The Director and Head of Healthcare 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, and are kept under review.

Liaison with the man's family

58. After the man was admitted to hospital on 6 and 18 April, prison staff contacted his partner and allowed her to visit him. However, on 27 April, nurses found seven subutex tablets hidden in his sock. (Subutex is a prescription only opioid drug that is similar to heroin and used in drug treatment as a heroin substitute.) As his partner had been his only visitor,

she was banned from visiting. Staff gave him and his partner a letter explaining this restriction.

59. On 14 October, during the man's last admission to hospital, he asked for his three children to visit him. This was approved and the prison allowed another family member to accompany them. His partner was still not allowed to visit him.

60. On 29 October, a hospital registrar said that the man was very unwell and suggested that the prison should contact his family so they could visit him. The prison lifted all visiting restrictions, and his partner and other family members visited at 5.00pm that day. The prison appointed a family liaison officer, who went to the hospital with a prison manager, to meet them. That day hospital staff fully informed him that his condition was critical and his partner stayed with him overnight.

61. The prison chaplain arranged for the man to marry his partner in hospital on 1 November. He died a few days later. His funeral was on 18 November, and the prison held a memorial service on 9 December. The prison contributed towards the cost of the funeral, in line with national policy.

Compassionate release

62. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

63. A nurse discussed a transfer to Holme House with the man on 30 October, a few days before he died. He was keen to move closer to his family, but wanted to be at home when he died. She agreed to enquire about the possibility of early release on compassionate grounds. She spoke to a manager, who advised that it was unlikely to be approved, due to his offences. Assessments for compassionate release should consider the extent to which the prisoner's illness means that the risk of re-offending has passed, rather than the actual offence, as all determinate sentenced prisoners who have not reached their parole eligibility date are eligible to apply. However, we recognise that he died very shortly after his diagnosis and there was too little time to pursue an application before his death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prison healthcare staff are familiar with National Institute for Health and Clinical Excellence (NICE) guidelines on the early diagnosis of cancer and that doctors refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.

2. The Director and Head of Healthcare 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, and are kept under review.

ACTION PLAN

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that prison healthcare staff are familiar with National Institute for Health and Clinical Excellence (NICE) guidelines on the early diagnosis of cancer and that doctors refer prisoners to a specialist urgently if they present with unexplained and persistent symptoms of suspected cancer.	Accepted	The Head of Healthcare will issue all prescribers with a copy of NICE guidelines sections – CG 131, *Colorectal cancer: The diagnosis and management of colorectal cancer* and CG27 *Referral Guidelines for Suspected Cancer*, which set out referral timelines guidelines for staff to adhere to.	31/05/2015 Head of Healthcare
2	The Director and Head of Healthcare 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, and are kept under review.	Accepted	A clinical risk assessment is carried out by a registered staff nurse prior to each prisoner's transfer to hospital, with reference given to the patient's medical records. Nurses then complete a Person Escort Record (PER) before the patient is transported to hospital. PER documentation training will be delivered by a senior nurse to all registered nurses involved in this process. This will all be taken into account before the security element of the risk assessment is completed and will be kept under review, with the security assessment being amended as any changes in circumstances occur.	31/05/2015 Head of Healthcare & Head of Security