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 December 2014, while 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 the man of lung cancer in December 2014, while a prisoner at HMP Northumberland. I offer my condolences to the man' family and friends.

On of my investigators carried out the investigation. A clinical reviewer was appointed to review the clinical care the man received at the prison. The prison cooperated fully with the investigation.

The man had been a prisoner at HMP Northumberland since 2008, after receiving an indeterminate sentence for public protection prison. He had a history of high blood pressure and type two diabetes, which healthcare staff monitored frequently. The man did not report any significant health problems until 21 November 2014, when a doctor prescribed antibiotics for a suspected chest infection. Two days later, the man was taken to hospital after he complained of chest pain and the hospital admitted him for assessment. Tests identified that he had incurable cancer, with little time left to live. The man's condition deteriorated rapidly and he died at the hospital in December.

I agree with the clinical reviewer that the man received very good care and support from staff at HMP Northumberland, equivalent to that he could have expected to receive in the community. However, I am concerned that the man remained restrained in hospital, until the day of his death, without a fully considered risk assessment to justify this.

The 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 13 December 2007, he man received an indeterminate sentence for public protection and began his sentence at HMP Leeds. On 9 July 2008, he transferred to HMP Acklington, now known as HMP Northumberland. He had a history of high blood pressure, high cholesterol and type two diabetes, but had little contact with healthcare staff, other than for routine diabetes and blood pressure checks.

2. On 21 November 2014, during a routine blood pressure check, the man told a doctor that his chest was tight and he had lower back pain. The doctor heard 'crackling' sounds on his chest and prescribed antibiotics.

3. On the evening of 23 November, the man told a wing officer that he had chest pain and was feeling unwell. An out of hours doctor advised that the man should go by ambulance to hospital for assessment. Two officers escorted him, using an escort chain to restrain him.

4. The man remained in hospital for tests, which indicated the possibility of cancer. On 27 November, a consultant confirmed that he had cancer in his lung and liver. The consultant told the man that the cancer was incurable and his prognosis was poor. The man remained in hospital, still chained to an officer.

5. On 2 December, a prison nurse visited the man in hospital and noted he was seriously ill and sedated. The nurse spoke to a manager about removing the man's restraints, who agreed to authorise this. Officers removed the escort chain at 1.10pm. The man died late that night, just after midnight.

6. We agree with the clinical reviewer that the man received a good standard of care at HMP Northumberland. However, we are concerned that the man remained restrained for so long in hospital when he was seriously ill, without a fully considered risk assessment to justify the use of restraints. We make one recommendation.

THE INVESTIGATION PROCESS

7. 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.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator informed the Director of the preliminary findings of the investigation.

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

10. We informed HM Coroner for North Northumberland of the investigation, who provided the cause of death. We have sent the coroner a copy of this investigation report.

11. We have been unable to contact any family members. The man had no contact with any family and did not give the prison any next of kin details.

12. The draft report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and an action plan has been added to the end of this report.

HMP NORTHUMBERLAND

13. 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 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

14. 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.

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Independent Monitoring Board

15. 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

16. The man was the seventh person to die from natural causes at HMP Northumberland since 2011. We have raised the issue of the inadequate use of restraints in hospital before.

KEY EVENTS

17. On 13 December 2007, the man received an indeterminate sentence for pubic protection, with a minimum period to serve of seven years before he could be considered for release. He began his sentence at HMP Leeds. At an initial health screen, a nurse noted the man had a history of high blood pressure, type two diabetes and high cholesterol. The man smoked cigarettes and did not want help to give up. On 9 July 2008, he transferred to HMP Acklington, now known as HMP Northumberland.

18. When he arrived at Acklington, a nurse assessed the man's medical conditions and a doctor reviewed his medications. Nurses arranged to check his diabetes and blood pressure regularly. The man's medical record shows that he did not attend 14 appointments to review his diabetes and blood pressure during his time at the prison. The records do not say why he did not attend, but show that he generally maintained good control of his diabetes and his blood pressure medication was adjusted as necessary.

19. Throughout his time in prison, the man did not receive any visits, letters or phone calls from his ex-wife or any other family members.

20. On 29 January 2014, Nurse A saw the man for a diabetic review. She recorded his blood pressure as high, at 200/110. There is no record that she arranged to follow up this high reading.

21. On 28 February, a prison GP, Dr A, reviewed the man's medication and recorded that his blood pressure was high. She noted that a doctor should further review the man in two weeks. Another prison GP, B, saw the man on 12 March. She recorded the man's blood pressure at 160/100, which was high, and adjusted his medication.

22. Records show that, for the next eight months, healthcare staff reviewed the man' diabetes and blood pressure frequently. The man's blood pressure fluctuated and doctors reviewed and adjusted his medication accordingly.

23. On 21 November, Dr A, saw the man to check his blood pressure. The man told the doctor that he had given up smoking ten days earlier and had tightness in his chest and lower back pain. The doctor examined him and noted raised blood pressure and some 'crackling' sounds in his chest. The doctor prescribed antibiotics and asked the man to make another appointment if his symptoms did not clear.

24. At 8.23pm on 23 November, the man rang his cell bell and told Officer A that he had chest pain and felt unwell. The officer radioed Senior Officer A, the senior member of staff on duty, to report the man's symptoms. The Senior Officer asked the communications room to telephone the out of hours GP service for advice. An out of hours doctor, told them to telephone for an ambulance to take the man to hospital for assessment.

25. At 9.50pm, Officer B and Officer C escorted the man to Wansbeck Hospital by ambulance. The officers used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The hospital admitted the man for tests.

26. On 24 November, preliminary medical tests indicated that the man might have cancer, but this needed further investigation.

27. On 26 November, doctors told the man that he had cancer deposits in his chest and liver. The next day, a consultant told the man that the cancer was incurable and his prognosis was poor.

28. Nurse B, from the prison, visited the man just after the consultant had informed him about his condition. He was upset and she offered him support. The nurse spoke to the man about the hospital's proposed plan for pain control and further investigations. She mentioned the possibility of him transferring to HMP Holme House, for full time nursing care, but the man said he would prefer to stay at HMP Northumberland.

29. The man asked Nurse B if someone could inform his ex-wife of his illness. Later that day, the nurse spoke to Officer D, who the prison had asked to support the man through his illness.

30. Officer D made enquiries with the man's offender manager (probation officer) about the possibility of contacting his ex-wife. However, his offender manager said that because of victim issues, there should be no contact with the man's ex-wife, who had not given her name as next of kin on any prison or probation documents.

31. On 28 November, at a hospital care meeting, doctors explained to the man that he would receive palliative care to control his pain and his maximum life expectancy was no more than two months. Later that day, Officer D visited the man at the hospital. The man was asleep and he decided not to disturb him.

32. On 29 November, prison manager, A, agreed that officers could remove the escort chain to allow the man some privacy when he took a bath or shower.

33. On 2 December at 12.15pm, Nurse B visited the hospital, to meet a palliative care nurse and discuss the man's care. Hospital staff told her that the man's condition had seriously deteriorated and doctors had sedated him. The nurse telephoned the prison manager, A, and he agreed that officers should remove the escort chain, which they did at 1.10pm. At 3.10pm, hospital staff fitted a syringe driver to give the man continuous pain relief. The man died later that night, and a member of hospital staff confirmed his death at 12.15am.

34. A Director's notice informed staff and prisoners of the man's death and offered support if anyone needed it. A senior officer debriefed the staff who had been involved in the man's care, particularly the escort officers.

35. A death certificate issued by the Senior Coroner for North Northumberland recorded that the man's death was of natural causes, from small cell lung cancer.

36. The prison arranged the man's funeral and the prison chaplain conducted the service on 18th December 2014. Officer D and an operational manager represented the prison.

ISSUES

Clinical care

37. We agree with the clinical reviewer that the man received a high standard of care for his medical conditions at the prison. The clinical reviewer considered that his care was equivalent to that he could have expected to receive in the community. Healthcare staff monitored his diabetes and blood pressure frequently, although the clinical reviewer noted that there was one occasion, in January 2014, when a nurse recorded a high blood pressure reading, but did not appear to arrange to follow this up. However, we are satisfied this did not impair his overall standard of care.

38. The clinical reviewer noted that there was evidence that healthcare staff provided some compassionate care. After doctors diagnosed the man with cancer, Nurse B visited him to offer emotional support and discussed his care and pain management with hospital staff on his behalf. The nurse made enquires with HMP Holme House in case the man might need the palliative care services offered in their healthcare centre. However, the man's condition deteriorated very quickly and he stayed in hospital until he died.

Use of restraints

39. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

40. The man' escort and transfer form was completed before staff took him to hospital on the evening of 23 November. There were no healthcare staff on duty at the time and the medical section of the form was not completed. The level of risk to the public and escape were not assessed but ticked as 'yes'. Although in pain, the man was mobile at the time. Two officers escorted him to hospital and restrained him with an escort chain.

41. On 24 November, a prison manager, B, completed an updated risk assessment, but there was still no clear assessment of risk and no healthcare input. She noted that officers should remove the restraints for medical treatment. Another prison manager, C, reassessed the risk the following day and made no changes.

42. On 29 November, prison manager, A, authorised the removal of restraints when the man bathed or showered, as well as for medical treatment, otherwise the man remained restrained until Nurse B contacted prison manager, A, about the man critical condition on the afternoon of 2 December.

43. We are satisfied that officers removed restraints for treatment and allowed the man privacy to attend to his personal hygiene unrestrained and that restraints were removed completely for the final hours of his life. However, we are concerned that, while the man was in hospital, there was insufficient assessment of his overall risk and no clinical input about his condition and the impact this had on his risk of escape, as required by the 2007 High Court judgment. This is an issue we have raised with the prison before. Although the prison has accepted previous recommendations, we have yet to see any substantive change in practice. We make the following recommendation:

The Director 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, are based on the actual risk the prisoner presents at the time, and are kept under review.

RECOMMENDATION

The Director 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, are based on the actual risk the prisoner presents at the time, and are kept under review.

ACTION PLAN: The man – HMP Northumberland

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Director 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, are based on the actual risk the prisoner presents at the time, and are kept under review.	Accepted	All healthcare staff will be reminded of the importance of recommending whether a prisoner is able to accomplish an escape unaided at the point of the initial risk assessment being completed. This recommendation will be taken into account by the manager authorising the risk assessment. When a prisoner is at outside hospital it is already accepted practice that healthcare staff keep in touch with the hospital. If a terminal illness is diagnosed, then a member of healthcare staff visits the hospital to speak to hospital staff and the prisoner. HMP Northumberland will ensure that when this happens, the member of healthcare staff will make an entry in the escort risk assessment with details of whether they support the removal of restraints. If healthcare staff support the removal, the escort staff will contact the Duty Manager immediately, and a decision will be made as to whether the restraints are removed. This decision will be recorded in the escort risk assessment by the escorting staff.	01 June 2015 Head of Security and Head of Healthcare