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 at HMP Holme House

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 from widespread cancer, at HMP Holme House on 13 October 2013. He was 46 years old. I offer my condolences to the man's family and friends.

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

The man had been in prison since May 1997. He had type 1 diabetes from childhood. In 2005, he was diagnosed with a slow growing cancer for which he received ongoing treatment for some years. There was never any clear prognosis and, in June 2011, he was told that his life expectancy could be between 12 months and 15 years.

The man's condition continued to deteriorate significantly in 2012 and he moved to HMP Holme House on 9 October 2012, as the prison was able to offer the palliative care he needed. The man did not always follow medical advice and as a result his pain control was problematic and his diabetes unstable. In April 2013, the man was told that his cancer had spread to other parts of his body. He was admitted to hospital several times, often with diabetic complications. He moved to the healthcare inpatient wing at Holme House in September, where he remained until he died.

The investigation found that the man received a good standard of care at Holme House and good efforts were made to meet his needs. However, I am concerned that restraints were used when the man was taken to hospital in September 2013. This was not justified by a fully considered risk assessment which took into account his medical condition at the time, a matter I have raised with Holme House a number of times before. The Governor needs to ensure that all staff taking decisions about the use of restraints for seriously ill and dying prisoners are aware of the legal position and follow national Prison Service guidance.

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 **July 2014**

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SUMMARY

1. The man was serving a life sentence for a serious sexual offence and assault. He had been in prison since 1997 and had spent time in a number of prisons before he transferred to HMP Holme House in October 2012.

2. The man had suffered from type 1 diabetes since childhood. In 2005, he was diagnosed with a slow growing cancer (carcinoid tumours) of the intestine. His consultant explained that his condition would deteriorate within one to two years. However, he survived for some time and, in June 2011, a consultant told him that because of the slow nature of the disease, his life expectancy could be anything between 12 months and 15 years.

3. The man's condition began to deteriorate and, in October 2012, he moved to HMP Holme House for palliative care. His care plans were reviewed at Holme House and he was assessed by a palliative care specialist, oncologist and Macmillan nurses. The man did not always follow medical advice for his cancer or diabetic regime and this made it difficult to manage both conditions. He was admitted to hospital a number of times with hypoglycaemic comas.

4. In April 2013, a scan showed that the cancer had spread. An oncologist suggested radiotherapy, which the man declined. He was referred to the specialist Macmillan service for palliative care in June and after that Macmillan nurses reviewed him regularly.

5. On 2 September, the man spent eleven days in hospital being treated for an infection. He returned to the prison but was admitted to hospital again for four days on 20 September, after he was found unresponsive in his cell. In hospital, the man signed a Do Not Attempt Resuscitation (DNAR) form. Until September, the man had lived on a standard wing at Holme House. When he was discharged from hospital he was admitted to the prison's inpatient unit and was cared for there until his death.

6. The man's condition deteriorated rapidly after he returned from hospital and, on 8 October, healthcare staff began an end of life pathway. On 13 October, the man stopped breathing. In line with his wishes, staff did not attempt to resuscitate him and a prison GP certified his death at 5.15pm.

7. A prison family liaison officer had been appointed when the man first arrived at Holme House and consulted the man about who he wanted to be contacted about his illness or death. The man did not want his family involved and his nominated next of kin, a friend, was informed of his death in line with his wishes.

8. The clinical reviewer concluded that the man was well cared for at Holme House, despite being difficult to manage. We agree he received a good standard of care at the prison but, as in a number of other cases at Holme House, we are not satisfied that the use of restraints when the man was in hospital was justified by a fully considered risk assessment.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

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

11. The investigator obtained copies of the man's relevant prison and prison medical records. The investigator and clinical reviewer spoke to a number of staff at HMP Holme House on 28 November 2013 and visited the healthcare inpatient facility and the palliative care suite. The investigator gave initial feedback to the liaison manager.

12. The investigator informed HM Coroner for Middleborough of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted a friend of the man, who was his nominated next of kin, to explain the investigation process. The man's friend did not have any specific issues he wanted the investigation to cover.

14. This investigation assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, liaison with his family, his location, whether compassionate release was considered; and security arrangements for escort and bedwatch.

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

HMP HOLME HOUSE

16. Holme House is a local prison for up to 1,212 men. The majority of its prisoners are remanded into custody or recently convicted by courts in the local area. Care UK provides health services at Holme House. There is an inpatient unit with 28 beds and 24 hour nursing care.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Holme House was in August 2013. Inspectors found that the overall standard of healthcare was good. There was a reasonable skills mix of healthcare staff, with 10 nurse prescribers. Health services were delivered from a health centre and wing based rooms, which were generally of a reasonable standard. The Inspectorate described palliative care at the prison as excellent with multi-departmental care based on best practice from Macmillan Cancer Support.

Independent Monitoring Board

18. 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 annual report for the year to December 2012, the IMB said that healthcare services were delivered to a high standard at least equivalent to services offered in the community. The IMB noted that a new palliative care suite was about to be opened.

Previous deaths at HMP Holme House

23. The man's death was one of six natural cause deaths at Holme House in 2013. We have made recommendations about the use of restraints in a number of these previous investigations.

ISSUES

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

19. The man had been diagnosed with a slow growing cancer of the intestines in 2005. It is evident from the man's medical records that he was aware of his diagnosis and that his original oncologist expected him to deteriorate within one to two years. The man had type 1 diabetes. He did not always follow his diabetic regime and often suffered from hypoglycemia where his blood sugar was too low and he required urgent medical treatment. This added to the complexity of his management.

25. The man spent time in a number of prisons and his oncology and diabetes care transferred between hospitals for each move. The man was well informed about his condition and, by 2009, was fully aware that the cancer had spread to his liver and bones. In June 2011, he transferred to HMP Wellingborough. On 25 June 2011, a consultant oncologist, wrote to the man and said that it was not possible to give him a definite life expectancy as his type of cancer was associated with a slow worsening over many years. He told the man that his life expectancy could be between 12 months and 15 years.

26. The clinical reviewer could not confirm at what point the man was considered terminally ill. The man was kept informed about his condition throughout his illness and sometimes corresponded directly with his doctors about the progress of the cancer. Although he was not given a clear prognosis, he was aware that the cancer was spreading

27. On 9 October 2012, following a deterioration in his condition, the man moved to HMP Holme House as it provided palliative care facilities. On 18 April 2013, the man had a reassessment scan. He was informed that the cancer had spread to his pancreas, duodenum and liver, but was still not given any clear prognosis. A large mass was also found in his small intestine and lesions in his lower spine.

28. We are satisfied that the man was well informed about his condition as it progressed and appropriately supported by healthcare staff.

The man's medical treatment

29. Records show the man was rarely completely pain free, although his pain relief was regularly reviewed. In 2012, in an attempt to alleviate his pain, he received a course of palliative radiotherapy to his upper pelvis. Records show that the man was well cared for. When transferred between prisons, his oncology and diabetic regime, although disrupted temporarily, continued with referrals to appropriate specialists.

30. When it is evident that a life limiting medical condition is not responsive to active treatment, it is appropriate that a palliative care plan is put into place.

The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

31. When the man transferred to Holme House on 9 October 2012, his care plans were reviewed and he was placed on a palliative care register. On 26 October, a specialist in palliative care assessed him and referred him to an oncologist at James Cook Hospital, Middlesbrough, and to the Macmillan nursing service. Nurses saw the man at least twice daily, and the prison palliative care lead nurse, also visited him.

32. Between October 2012 and April 2013, the man's condition and treatment was effectively managed by both healthcare and hospital staff. We were told that regular multi-disciplinary meetings were held to discuss the man's care and treatment, but these were not documented. On 6 March 2013, the man was found unresponsive in his cell due to low blood sugar and was subsequently found to have a broken hip. He initially declined treatment, but then agreed to a hip replacement operation on 20 March.

40. On 21 May, his pain relief was increased on the advice of his oncologist. However, the man refused a course of radiotherapy to help alleviate his pain. On 13 June, the man was referred to the Macmillan service for palliative care. A specialist nurse practitioner reviewed him on the 24 June and Macmillan staff saw him frequently from then on.

41. During the last few months of his life, the man's diabetes remained unstable and he experienced several episodes of hypoglycaemic coma, which required emergency treatment in hospital. The clinical reviewer noted that every effort appears to have been made to monitor and stabilise the man's condition and it was difficult to see how his diabetic care could have been improved.

42. The man's appetite was poor and he was prescribed food supplements but was unable to maintain his weight. On 2 September, the man was unwell but refused admission to the prison's healthcare unit. Later that day, he agreed to go to hospital where he was diagnosed with a possible clostridium difficile infection (bacterial infection affecting the digestive system). The man remained in hospital until 13 September.

43. At 8.45am on 20 September, the man was found unresponsive in his cell, with low blood glucose levels. He was taken by ambulance to North Tees General Hospital. His condition stabilised and he was discharged back to the prison's inpatient unit on 24 September. He had signed a Do Not Attempt Resuscitation (DNAR) order at the hospital and the nurse discussed and reviewed the DNAR with him on 24 September. (A DNAR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided).

44. The man's condition began to deteriorate after his return to prison. He was found on the floor of his room twice and was incontinent and confused. He became steadily worse and, on 6 October, fell unconscious. A syringe driver was set up to deliver pain relief and medication and the door of the man's cell in the impatient unit was left open to allow healthcare staff easy access.

45. On 8 October at 6.40pm, the man was placed on the Prison Integrated Care Pathway for End of Life Care. (An end of life pathway is for the last weeks and days of life. The patients wishes regarding resuscitation should be documented and a DNAR in place if agreed. All treatment apart from pain and symptom relief is withdrawn and the patient's comfort is the priority.)

46. At 2.17pm on Sunday 13 October, the man stopped breathing while being attended to by a nurse. In line with his wishes, the nurse did not attempt to resuscitate him. Later that afternoon, a prison GP certified his death.

47. A post-mortem examination concluded that the man had died from bronchopneumonia and metastatic carcinoid tumour.

48. The clinical reviewer noted that the man was a challenging person to nurse. However, it was evident that appropriate care plans were put in place and these were well managed. He was seldom totally pain free but, overall, his symptoms and pain relief were controlled throughout his illness and he was well cared for.

The man's location

49. The man had been in prison since 1997 and had spent time in a number of different prisons. It is not clear whether his diagnosis was taken into account once it was known, but his moves meant that he was under the care of a number of different consultants. In October 2012, when his condition deteriorated, he moved to HMP Holme house as the prison could offer 24 hour nursing and palliative care.

50. The man preferred to remain on a standard wing for as long as possible and this wish was respected. Healthcare and prison staff looked after him on the wing and he was offered the opportunity to move to the healthcare unit on several occasions, but declined. However the man's condition deteriorated and he became almost immobile by the beginning of September. When he returned from hospital on 24 September 2013, he moved permanently to the prison's healthcare inpatient unit.

51. We are satisfied that the man's wishes about his location were taken into account and respected. He was appropriately moved to Holme House and then to the inpatient unit as his condition deteriorated.

Restraints, security and escorts

52. 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 also deemed that restraining by handcuffs of 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.

53. The man frequently attended hospital either for ongoing treatment, clinic appointments or emergency admissions. The use of consultations via Telemeds, a video link from the prison to hospital, was useful and reduced the need for some escorts to hospital.

54. At approximately 4.15pm on 2 September, the man was taken to hospital by ambulance. The nurse completed the healthcare section on the risk assessment form and objected to the use of restraints because of the man's poor health and weakness. Despite this, the man was restrained in handcuffs for the journey. He remained restrained until 8.00pm when the duty governor reviewed the restraints risk assessment and instructed that the restraints be removed immediately because of the man's condition.

55. On 20 September, the man was taken to hospital by emergency ambulance. A nurse recorded in the medical officer's report that she was concerned about the man's health and noted he was unconscious, but indicated on the risk assessment form that there were no medical objections to the use of restraints. She did not comment how his medical condition impacted on his risk of escape as the court judgement requires. The security department noted that the man's behaviour was good and that he was very ill and quiet. It was also recorded that he had no history of escape, his current risk was low and there was no known risk to hospital staff.

56. Despite this assessment, the Head of Security decided that the man should be restrained by 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) both on the journey and throughout his four day stay in hospital.

57. We are concerned that on both these occasions the man was restrained without appropriate justification and full consideration of how his health and mobility affected his risk. On 2 September, despite the objection of healthcare staff he was restrained until a prison manager reviewed this several hours later. On 20 September, he was restrained throughout his stay in hospital, although he was very sick and unconscious at the time. This had been identified by healthcare staff, but not reflected in the risk assessment. We are not satisfied that restraints on each occasion were justified by a fully

considered risk assessment that took into account the man's risk and condition at the time and we are concerned that little heed appears to have been paid to the 2007 High Court judgement, a matter we have raised with Holme House before. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

58. A prison family liaison officer was appointed when the man arrived at Holme House and kept in contact with him about his wishes. The man was not in contact with his family and had nominated a friend as his next of kin. On 27 September another prison family liaison officer, took over the role.

59. On 8 October the Safer Prisons and Equality Manager at Holme House was told of the man's failing health. He tried unsuccessfully to contact the man's friend by telephone. He left a message on his answerphone and sent a letter asking him to make contact. Later that day, the man confirmed that he did not want his family to be informed of his condition and that his friend was to be contacted after his death.

60. On 8 October, the family liaison officer spoke to the man's friend by telephone, to inform him of his deteriorating health. The man's friend was unable to visit, but asked to be informed by telephone when the man died.

61. On 14 October, another prison family liaison officer telephoned the man's friend and told him of his death. The funeral was arranged and paid for by the prison and took place on 28 October.

62. The prison tried to find the man's brother and eventually contacted him on 8 November to inform him about what had happened. He visited the prison and received the man's property.

Compassionate release

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

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64. After his diagnosis in 2005, the man applied for parole on several occasions but was unsuccessful. His application for parole on 8 August 2013 was rejected, as the panel concluded that he posed a significant risk that could only be safely managed in custody. The panel directed he should not be released or moved to an open prison. In light of this, and because the man had never been given a clear prognosis of less than three months, he was not considered suitable for release on compassionate grounds.

RECOMMENDATION

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Prison and Probation Ombudsman's learning lessons update from February 2013 was re-circulated to all Duty Governors and Custodial Managers in February 2014, who have been reminded that risk assessments for prisoners taken to hospital are based on a consideration of the individual's health circumstances and the actual risk the prisoner presents at the time. Extracts from the PPO update were highlighted to remind staff of the legal obligations. This update is now on a circulation list to be reissued annually. HMP Holme House's escort risk assessment form is being redesigned to ensure it highlights the present health condition of prisoners.	Complete April 2014 Security Dept	