PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# Independent investigation report by the Prisons and Probation Ombudsman Nigel Newcomen CBE into the death of a prisoner at HMP High Down, 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 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 from lung cancer on 2 February 2015, while a prisoner at HMP High Down. He was 54 years old. I offer my condolences to the man's family and friends.

The investigation found that the man's care in prison was equivalent to that he could have expected to receive in the community. A hold up in receiving X-ray results should not have delayed a referral for suspected cancer, but the clinical reviewer did not consider that this would have altered the outcome for the man. I am concerned that the man was restrained for some hospital appointments, without fully considered risk assessments which took into account his health and mobility.

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **August 2015**

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## SUMMARY

### Events

1. In June 2014, the man was remanded to HMP Wormwood Scrubs. In August 2014, he moved to HMP High Down. On 8 September, he was sentenced to 12 years in prison.

2. The man had smoked cigarettes for 45 years. In July 2014, at Wormwood Scrubs, the man reported having a chesty cough from which he appeared to recover. Doctors attributed this to an infection. After he arrived at High Down, he continued to have a cough. A GP prescribed antibiotics for an infection and requested blood tests and a chest X-ray. The X-ray was taken on 18 August. By 22 September, the X-ray results had not been received and a GP made an urgent hospital referral for suspected cancer. The X-ray report arrived the next day and showed the man had a mass in his right lung. After tests, on 6 October, a hospital doctor told the man that it was likely he had cancer. On 21 October, further tests confirmed that the man had terminal lung cancer.

3. During a hospital stay in November, doctors found the man had a deep vein thrombosis (DVT) in his right leg and prescribed antibiotics and anticoagulant treatment. On 1 December, an oncologist suggested palliative radiotherapy to help relieve his symptoms. (Unfortunately the man soon became too unwell to benefit from this.) On 10 December, the man was admitted as in inpatient to the prison's healthcare unit, as his condition deteriorated. From 11 December to 15 January 2015, the man was treated in hospital for a collapsed right lung. His condition deteriorated significantly.

4. When the man returned to High Down on 15 January, he was nursed palliatively in the healthcare unit. His wife visited him daily. On 30 January, the man transferred to a hospice where he died on 2 February 2015.

### Findings

5. The clinical reviewer found that the man's symptoms were well recorded and investigated and the care that he received was equivalent to that he could have expected to receive in the community. However, while this did not affect the eventual outcome, he considered the hold up in receiving the X-ray results should not have delayed his referral to a specialist. We consider that the man was restrained without proper justification when attending hospital appointments.

### Recommendations

- **The Head of Healthcare should ensure that staff chase up outstanding test results when GPs request them and record their actions and the outcome in the medical record.**

- **The Head of Healthcare should ensure that prisoners with symptoms suggestive of cancer are referred to specialists urgently, in line with NICE guidelines.**

- **The Governor and the Head of Healthcare should ensure 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.**

## THE INVESTIGATION PROCESS

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

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

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

9. We informed HM Coroner Surrey of the investigation who provided the cause of death. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the man's wife to explain the investigation. She did not have any specific matters for the investigation to consider.

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 has submitted an action plan detailing what they have done to address the issues we raised, and this is included at the end of the report.

## BACKGROUND INFORMATION

### HMP High Down

13. HMP High Down is a local prison near Sutton, in Surrey, which holds up to approximately 1,100 men. Healthcare is provided by Virgin Care and at the time of the man's death local GPs from Cheam Family Practice provided GP services. Care UK provides out of hours cover. The healthcare unit has inpatient facilities with 24 hour nursing cover,

### Her Majesty's Inspectorate of Prisons

14. The most recent inspection of HMP High Down was in January 2015. Inspectors found that healthcare services were good but staff shortages resulted in the cancellation of too many appointments. Staff provided good care in the inpatient unit but prisoners there spent too much time locked in their cells.

### 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 recent published report for the year to December 2014, the IMB reported that health care provision at High Down compared well with other prisons.

### Previous deaths at HMP High Down

16. The man was the ninth prisoner to die of natural causes at High Down since January 2013. We have raised the issue of unjustified use of restraints before.

## FINDINGS

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

17. The man was remanded to HMP Wormwood Scrubs in June 2014. His reception health screen noted he had smoked cigarettes for 45 years. No other significant health matters were recorded.

18. On 27 July, the man told a prison GP that he felt 'chesty'. He said that in the past had been given cough medicines, antibiotics and a ventolin inhaler (which opens the airways), for this condition. The GP recorded that he probably had an exacerbation of chronic bronchitis and prescribed an inhaler.

19. On 29 July, another prison GP examined the man because he had coughed up blood stained sputum. The GP took a full history and requested a sputum culture and a chest X-ray.

20. On 30 July, a prison GP reviewed the man and arranged for blood tests, including a D-dimer test (to detect any pieces of blood clot in the blood stream). All the test results came back as normal, apart from the D-dimer test which was raised. (A raised D-dimer test can indicate the possibility of an embolism (blood clot), infection or disease.)

21. On 4 August, a prison GP commented that the man's chest was completely better and attributed the raised D-dimer test result to an infection.

22. On 8 August, the man moved to High Down. At his reception screening a nurse noted that he had stopped smoking and that his recent blood test results were normal. As he still had a cough, the nurse made an appointment for him to see a doctor.

23. A prison GP saw the man on 15 August and diagnosed a lower respiratory tract infection, for which he prescribed antibiotics. He arranged a chest X-ray and further blood tests. On 18 August, a visiting radiographer took an X-ray of the man's chest. The radiographer sent the digital image to a consultant radiologist at Royal Surrey County Hospital, who reports on X-rays taken at High Down.

24. On 21 August, a prison GP saw the man because he was coughing up blood. He noted the prison had not yet received the X-ray results and asked for someone to chase them up. He asked the man to continue his course of antibiotics. On 3 September, another prison GP reviewed the blood test results that a GP had requested. He noted that he had raised platelets (indicative of possible infection) and abnormal liver function tests. The GP also asked staff to chase the X-ray, and noted these were now urgent. There is no record that anyone chased up the X-ray results.

25. On Tuesday 16 September, a GP saw the man and noted that he was still coughing up blood and was short of breath. He asked staff to chase up the X-

ray results again urgently. A GP noted that if the results were not received by the following Monday, 22 September, the man should 'be referred anyway'.

26. On 21 September, the man told a nurse that he had coughed up a lump of 'tissue'. She noted that he had lost weight and had increased shortness of breath. A nurse asked a doctor to consider sending the man to hospital for another X-ray and refer him urgently under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

27. On 22 September, a prison GP made an urgent referral for suspected cancer. The next day, the prison received a faxed X-ray report from the consultant radiologist completed on 20 September (33 days after the X-ray had been taken). The report said there was a mass in the right lung. The consultant radiologist recommended a chest clinic referral to rule out malignancy.

28. On 6 October, a respiratory specialist saw the man at Epsom General Hospital. He told the man that it was likely that he had lung cancer and requested further tests.

29. On 16 October, the man had a bronchoscopy and biopsies. On 21 October, a consultant medical oncologist told the man that he had incurable lung cancer.

30. The clinical reviewer concluded that overall the man's symptoms were well recorded and appropriately investigated at both Wormwood Scrubs and High Down.

31. However, there was a delay in the reporting of the man's chest X-ray. The consultant radiologist acknowledged that 33 days was an inadequate turnaround for a chest X-ray report. He told the clinical reviewer that at the time of the man's X-ray there had been technological problems, including X-rays from the prison arriving corrupted and needing to be resent. He said these issues had now been resolved. However, we are concerned that there is no record of any member of healthcare staff chasing up the X-ray result, as GPs had requested, and no one alerted them to any problems.

32. Although the GPs noted that the X-ray results had not been received, and asked for them to be chased urgently, they did not consider referring the man earlier without the results. The clinical reviewer noted that the National Institute for Health and Care Excellence (NICE) guidelines say that an urgent referral to a lung cancer team should be made while waiting for chest X-ray results, if there is persistent haemoptysis (coughing up blood) in a smoker or ex-smoker older than 40 years. A doctor eventually made an urgent referral on 22 September 2014, five weeks after the man first presented with a two-week history of coughing up blood. The clinical reviewer said that an earlier referral would have been preferable, but it is unlikely that it would have altered the outcome for the man. We make the following recommendations:

**The Head of Healthcare should ensure that staff chase up outstanding test results when GPs request them and record their actions and the outcome in the medical record.**

**The Head of Healthcare should ensure that prisoners with symptoms suggestive of cancer are referred to specialists urgently, in line with NICE guidelines.**

## The man's clinical treatment

33. Shortly after his diagnosis, the man became increasingly breathless and immobile as a result. On 19 October, the prison agreed that his family could provide him with a wheelchair to help him get about.

34. On 21 October, a consultant medical oncologist saw the man and explained the treatment for his condition. Although his condition was incurable, this would involve a three-weekly chemotherapy regime to help relieve his symptoms. The man also met a lung cancer nurse specialist who would liaise with the man and High Down. On 25 October, a healthcare assistant noted that the man was fully aware that he had terminal cancer. The man had told him that his wife and mother knew about his condition and were supporting him.

35. On 7 November, the man had a bronchoscopy which revealed a large tumour causing an obstruction. Doctors took biopsies and inserted a stent to help relieve the obstruction. The hospital discharged him the next day.

36. At about 1.52am on 11 November, a nurse examined the man in his cell, after he had coughed up blood and the stent inserted a few days earlier. A nurse noted that he was short of breath and recorded his oxygen level at 94% (the lower end of normal). She spoke to the on-call cardiothoracic registrar at St George's Hospital, Tooting, who advised her to give the man oxygen, nebulised salbutamol and monitor his respiration. She took the man to the healthcare unit where staff monitored him overnight. At 8.33am, a nurse reviewed the man and noted his oxygen level had dropped to 88% (very low), which increased to 99% when she gave him more oxygen. A nurse spoke to the registrar who advised her to send the man to the nearest hospital. An ambulance took the man to St Helier Hospital, Carshalton.

37. The man was admitted to hospital for treatment. On 14 November, investigations in hospital revealed he had a deep vein thrombosis (DVT) in his right leg. Doctors treated him with intravenous antibiotics and dalteparin injections (to prevent blood clots). He returned to the inpatient unit at High Down on 25 November and went back to his wing on 28 November, at his request. When he got back to High Down, a pharmacist spoke to a ward doctor at St Helier Hospital about the man's anticoagulant treatment and they agreed to prescribe warfarin (oral anticoagulant) rather than injections. The clinical reviewer considered that she should have discussed this with a consultant and has made a recommendation about this in his review, which the Head of Healthcare will need to address.

38. On 1 December, a consultant medical oncologist at the Royal Marsden Hospital reviewed the man and noted that the immediate concern was his

airways. He considered that chemotherapy would not be the best approach to improve his symptoms. Another oncologist discussed palliative radiotherapy with the man as an alternative to chemotherapy but this did not proceed as the man became too ill.

39. On 10 December, officers on the man's wing were concerned about his condition. A nurse reviewed him and noted he looked weak and that his right leg was swollen and painful. A doctor examined him shortly after and recorded that his anticoagulant medication needed adjusting. He prescribed alternative medication and admitted the man to the prison's healthcare unit as an inpatient.

40. On 11 December, the man complained of chest pain and shortness of breath and a nurse called a code blue (an emergency medical code that indicates breathing difficulties and prompts the control room to call an ambulance). Paramedics took the man to Epsom General Hospital. Doctors found he had a collapsed right lung and treated him with intravenous antibiotics. A scan revealed bone changes caused by lung cancer. The man stayed in hospital to stabilise his condition.

41. On 15 January 2015, the hospital discharged the man and he returned to the inpatient unit at High Down for end of life care. The discharge letter said that the man's condition had deteriorated significantly while he was in hospital and palliative radiotherapy was now not possible. He needed help with help personal hygiene, as he was now doubly incontinent.

42. A GP discussed resuscitation with the man and after speaking to his wife, he agreed that he did not want staff to attempt resuscitation if his heart or breathing stopped. On 18 January, a healthcare manager implemented an end of life care plan.

43. On 20 January, a member of the community palliative care team, a nurse, assessed the man. His wife was with him at the time. A nurse wrote to the prison the next day and recommended that end of life medication (to prevent pain, nausea and agitation) should be made available if needed. She also said that staff should refer the man to St Raphael's Hospice. Sutton, as his condition deteriorated.

44. On the morning of 29 January, a nurse noted that the man's condition had deteriorated further. He appeared to be in pain and was very agitated. A nurse agreed to admit the man to St Raphael's Hospice the next day. The man was taken to the hospice on 30 January and died there on 2 February. The coroner confirmed the cause of death was lung cancer.

45. We are satisfied that the man received an appropriate standard of end of life care at High Down. The clinical reviewer concluded that his care was equivalent to that he could have expected to receive in the community.

## The man's location

46. After his diagnosis, the man mostly lived on a standard residential wing, which he preferred, but was admitted to the healthcare unit as an inpatient when he needed closer monitoring and nursing care. He had two long stays in hospital, one in November 2014 for 14 days and another in December and January 2015 for 35 days.

47. On 10 December 2014, the man moved to the healthcare unit and did not return to his wing. He had a hospital bed to help him sit up independently. In January, the prison agreed that his door should remain unlocked at all times to allow nurses ready access to care for him.

48. As part of his end of life care planning the man said he would prefer to die in a hospice and he was taken to St Raphael's Hospice three days before he died. We are satisfied that the man was appropriately accommodated throughout his illness and the prison took account of his preferences.

## Restraints, security and escorts

49. 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.

50. On 5 December, the man went for a scan at the Royal Marsden Hospital. A prison manager noted that the man was a category B prisoner and there was no escape intelligence. The prison manager authorised two escort officers and that double handcuffs should be used for the journey and an escort chain when the man was undergoing treatment or being moved in a wheelchair. Double handcuffs means that the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. Double handcuffing is usually required for moving category A or category B prisoners in good health. 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.

51. There was no information written in the medical section of the risk assessment about the man's health or mobility and how it impacted on his risk of escape. A tick box indicated there were no healthcare objections to the use of restraints. The assessment indicated that the risk of escape was

considered ‘normal’ and that an officer who worked on the man’s wing had informed the security department that the man was “wheelchair bound’.

52. On 11 December, the man went to Epsom General Hospital as an emergency and remained there until 15 January. The escort risk assessment authorised double handcuffs for the journey and an escort chain in hospital. As before, the medical section was not completed and a tick box indicated there was no healthcare objection to the use of restraints, which is not the test required. There was no information about the man’s state of health or mobility. While the man was in hospital, managers completed new risk assessments on 16, 19 and 29 December. Each time, they authorised the continued use of an escort chain.

53. On 16 December, a member of healthcare staff (the name is not legible) noted there were no objections to the use of restraints, but stated the man was physically weak and poorly. On 19 December, there was no objection to the use of restraints noted and no information about the man’s medical condition. In fact the medical section of the risk assessment was crossed through. On 29 December, a member of healthcare staff noted that there was a healthcare objection to the use of restraints and noted that the man was bed bound. Despite this, the risk assessment, authorised by the prison manager, indicated the man should be double handcuffed for the journey and an escort chain applied for treatment.

54. On 5 January 2015, the prison manager reviewed the risk assessment and agreed that officers should remove the escort chain unless the man became mobile. The man was not restrained again. When he went to St Raphael’s Hospice, one officer, in plain clothes, accompanied him for support.

55. While we note that the man was not restrained at the very end of his life, we do not consider that there were appropriately considered risk assessments to justify their use before that. There was no meaningful healthcare input as the 2007 High Court judgment requires for most of the assessments. On 29 December, when a healthcare objection was raised. There is no indication that the manger who reviewed the security arrangements took this into account.

56. In December, the man was seriously and terminally ill, very weak and needed a wheelchair. The possibility of escaping from a two officer escort seems highly unlikely. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner’s individual circumstances. It is the Governor’s responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process – particularly when prisoners are terminally ill. We make the following recommendation:

**The Governor and the Head of Healthcare should ensure 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

57. High Down appointed a custodial manager as the family liaison officer. The family liaison officer supported the man and introduced herself to his wife when he returned from hospital on 15 January 2015. The family liaison officer arranged for flowers, and ensured there was a television and a radio in the man's cell in the healthcare unit, when he returned from hospital. The man's wife was allowed to bring in a DVD player for him.

58. The family liaison officer arranged for the man to have daily visits with his wife in the healthcare unit. On the night before the man moved to the hospice, she offered his wife the opportunity of staying overnight with him, but she chose not to.

59. It is clear from the records that the man kept his wife fully informed of his condition and discussed any important decisions about his care with her. Prison staff kept the man's wife involved in discussions about his ongoing care and on 20 January, a nurse spoke to her about managing his end of life care.

60. On 30 January, when the man transferred to the hospice, his wife and other members of his family were able to visit him daily. His wife was present when he died. The family liaison officer arranged the funeral, at the family's request. The prison contributed towards the costs, in line with national guidance.

61. We consider that the man and his family received commendably good support from the family liaison officer.

## Compassionate release

62. Prisoners can be released 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.

63. On 22 December, the prison considered whether the man was suitable for compassionate release. The Governor decided that because he had received a sentence of 12 years so recently (in September 2014) it was unlikely that he would be suitable for compassionate release and he did not support the application progressing. Factors to be taken into account in considering such applications include the length of the sentence still outstanding and the effect on the overall sentence passed by the court if early release is granted. We are therefore satisfied that the Governor's decision was reasonable.

| Action Plan: The man, HMP High Down Prison on 2/2/15 | | | | | |
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| **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 staff chase up outstanding test results when GPs request them and record their actions and the outcome in the medical record.** | Accepted | The Head of Healthcare will brief all GPs to contact the Healthcare admin department if they require test results to be chased up. This will ensure there is a written record of all requests and will ensure accountability.<br>Test results will only be marked as complete once they have been received. This will be audited via the medical computer system. | Target date for completion: 1/10/15<br><br>Head of Healthcare | |
| 2 | **The Head of Healthcare should ensure that prisoners with symptoms suggestive of cancer are referred to specialists urgently, in line with NICE guidelines.** | Accepted | The Head of Healthcare will brief all GP's that when a patient is presenting with symptoms suggestive of cancer they must refer them to the relevant specialist department using the two week rule referral template. This is in line with NICE guidelines. | Target date for completion: 1/8/15<br><br>Head of Healthcare | |
| 3 | **The Governor and the Head of Healthcare should ensure 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 Hospital Risk Assessment used by HMP High Down was revised early January 2015, to take into account the legal position around the use of restraints. This ensures that all staff involved in prisoner escorts to hospital have the information available to them with regards to the security concerns and health needs of the prisoner , allowing for a more informed decision of the risk the prisoner poses and the level of restraints to be used (if any). | Completed<br><br>Governor and Head of Healthcare | |