Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eugene Sinclair a prisoner at HMP Grendon on 3 November 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

Mr Sinclair died of lung cancer in hospital on 3 November 2015, while a prisoner at HMP Grendon. He was 38 years old. I offer my condolences to Mr Sinclair's family and friends.

I consider that Mr Sinclair received a high standard of care at Grendon, equivalent to that he would have expected to receive in the community. Mr Sinclair did not have typical symptoms which would have led doctors to suspect cancer and I am satisfied that healthcare staff investigated his symptoms appropriately and referred him for specialist investigation promptly. Mr Sinclair received good support from staff and other members of his therapeutic community at the prison throughout his illness and there was appropriate supportive liaison with his family.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

Summary

Summary

Events

1. On 7 December 2009, Mr Eugene Sinclair received a life sentence for murder. He had been at HMP Grendon since July 2012.

2. In May 2015, Mr Sinclair developed a pain under his right shoulder blade, which was originally considered to be muscular. He received anti-inflammatory medication, pain killers and physiotherapy. However, Mr Sinclair's pain increased and on 28 July, a doctor referred him for an urgent orthopaedic assessment.

3. The hospital admitted Mr Sinclair the next day and on 30 July, a doctor diagnosed a pancoast tumour (a condition where a lung cancer spreads from the lungs and into the bones, nerves and other tissue of the shoulder and neck). The hospital arranged a specialist palliative care nurse and, after further tests, discharged Mr Sinclair on 3 August.

4. On 21 August, an oncologist informed Mr Sinclair that he had advanced inoperable cancer. He explained that a combination of radiotherapy and chemotherapy might shrink the tumour but his life expectancy was likely to be months.

5. Prison healthcare and palliative care nurses treated and managed Mr Sinclair's symptoms and he often went to hospital for assessment and secondary care. In mid-October, doctors said the tumour had shrunk and he completed radiotherapy later that month. On 31 October, after becoming disorientated and dehydrated, he was admitted to hospital and doctors suspected that the cancer had spread to his brain. Mr Sinclair died in hospital on 3 November 2015.

Findings

6. We are satisfied that the care Mr Sinclair received at Grendon was equivalent to that he could have expected in the community. Pain relief, medication, tests, investigations, referrals and treatments were appropriate and timely. Prison healthcare staff took great care to support Mr Sinclair at the time of his diagnosis, during his treatment and in the last weeks of his life and he also received good support from other prisoners. There was appropriate family liaison and reasonable decisions were taken about security arrangements when Mr Sinclair was taken to hospital. We consider that the prison properly pursued an application for compassionate release but, sadly, Mr Sinclair died before this was considered.

7. Grendon has no inpatient or end of life care facilities. This did not affect the standard of care given to Mr Sinclair and we make no formal recommendations, but we agree with the clinical reviewer that prison and healthcare managers need to consider and agree suitable contingency plans for end of life care.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Sinclair's prison and medical records.

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

11. We informed HM Coroner for Buckinghamshire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Sinclair's mother to explain the investigation and to ask if she had any matters the family wanted the investigation to consider. She asked if staff had assessed Mr Sinclair's symptoms correctly, if his referral and diagnosis were timely and if the medication prescribed was appropriate.

13. The investigation has assessed the main issues involved in Mr Sinclair'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. Mr Sinclair's mother received a copy of the initial report. She pointed out a factual inaccuracy and this report has been amended accordingly. Mr Sinclair's mother also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. The clinical reviewer received a copy of the initial report. She pointed out a number of areas for clarification and this report has been amended accordingly.

16. We shared the initial report with the Prison Service and there were no factual inaccuracies.

Background Information

HMP Grendon

17. HMP Grendon holds up to 238 men and accepts prisoners serving indeterminate or long determinate sentences with at least 24 months left to serve. It is a unique prison, run by prisoners and staff on democratic therapeutic principles. It has six wings, five of which operate as autonomous therapeutic communities. The sixth is an induction and assessment wing.

18. Care UK provides healthcare services from 8.00am to 7.00 pm on Monday to Friday and 9.15am to 5.00pm on Saturday and Sunday. There is no inpatient unit. Oxford Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Grendon was in August 2013. Inspectors reported that Grendon was a very safe prison with excellent staff-prisoner relationships and very little need for formal disciplinary processes. The prison had refurbished the health centre's clinical rooms to a high standard, although capacity was limited. Patient care, dentistry and pharmacy provision were good, but the prison needed to assess the risks associated with in-possession medication. Mental health care had improved.

20. Care plans reflected national clinical guidelines and were audited monthly. Care UK had an information sharing protocol but no formal local protocol agreed with HMP Grendon. External healthcare appointments were rarely cancelled for security reasons.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. There is no recent published IMB annual report. In the report for the year to December 2012, the IMB said that health services had improved. Nurses frequently attended the wings and held regular meetings with wing therapists and prisoner representatives.

Previous deaths at HMP Grendon

22. Mr Sinclair's death was the first at HMP Grendon from natural causes since the Ombudsman started investigating deaths in prisons in April 2004.

Findings

The diagnosis of Mr Sinclair's terminal illness and informing him of his condition

23. On 7 December 2009, Mr Eugene Sinclair was sentenced to life imprisonment for murder. He had a history of depression, and alcohol and drug misuse. Mr Sinclair had been at Grendon since July 2012. He smoked cigarettes and found it difficult to stop, despite advice and help. He was in generally good health and had little contact with prison healthcare services.

24. On 6 May 2015, Mr Sinclair reported nasal congestion and said that for the last four days he had felt pain under his right shoulder blade when he coughed. A triage nurse examined Mr Sinclair and found that his chest sounded clear. She diagnosed hay fever and musculoskeletal pain (pain in the muscles, ligaments and bones). She gave him cetirizine (an antihistamine) and nicotine replacement therapy to help him stop or reduce cigarette smoking. She referred him to the prison GP, but told him to see her again if the pain increased or his symptoms did not improve.

25. On 27 May, Mr Sinclair did not attend a GP appointment. On 2 June, a nurse referred him to a prison GP, as he had numbness in his upper arm. Mr Sinclair's shoulder pain and numbness in his right arm persisted and, on 10 June, a locum GP arranged for him to see a physiotherapist. She prescribed naproxen (an anti-inflammatory painkiller). On 20 June, a nurse noted that there were no obvious 'red flag' signs. The GP saw Mr Sinclair again on 24 June and prescribed codeine for pain.

26. Mr Sinclair did not attend a planned appointment with the physiotherapist, on 1 July. Two days later, he told a GP that he still had numbness in his right arm and armpits. He said the pain was getting better, but he needed something to take at night. He did not want codeine. The GP diagnosed muscular pain and possible nerve damage, and prescribed ibuprofen. He considered that Mr Sinclair might need to see a neurology specialist, but did not refer him at the time.

27. On 15 July, a physiotherapist assessed Mr Sinclair, who said he had pain in his right arm, shoulder and neck. A nurse noted reduced movement in his neck and diagnosed neuralgia (nerve pain). She gave Mr Sinclair exercises and advised him to use hot and cold pads and to support his neck with a towel. Mr Sinclair suggested he needed different medication for his pain, such as gabapentin or pregabalin. She discussed this with a GP, but the GP was concerned about possible dependency and misuse and did not change his medication.

28. On 20 July, a GP arranged blood tests, as his symptoms had not improved. The next day, another GP referred Mr Sinclair for an MRI scan. The blood test was normal for kidney and liver function and blood protein, but Mr Sinclair's white cell count was raised, commonly caused by an infection.

29. On 22 July, Mr Sinclair told the triage nurse he had numbness in the fingers of his right hand. She referred him to the GP and a GP saw him later that day. During the next week, GPs and nurses reviewed his medication and pain control and arranged repeat blood tests. On 28 July, when test results showed

significant abnormalities, a GP contacted the medical registrar at hospital and arranged an urgent orthopaedic assessment.

30. The hospital admitted Mr Sinclair the next day. The medical records show that an MRI scan indicated a shoulder abscess however, on 30 July, after further examination, a hospital doctor told a nurse at Grendon that Mr Sinclair had a pancoast tumour (a condition where lung cancer spreads from the lungs and into the bones, nerves and other tissue of the shoulder and neck). Mr Sinclair had further tests to confirm the diagnosis, the stage of the disease and to inform treatment.

31. On 2 August, the nurse visited Mr Sinclair in hospital. His family was with him, and they discussed his diagnosis, treatment and pain relief. Mr Sinclair went back to Grendon on 3 August, with a discharge letter detailing his medication and planned outpatient appointments. On 4 August, the nurse and Mr Sinclair had a long discussion about his diagnosis, care, treatment, and welfare. The nurse agreed to accompany him to hospital appointments.

32. The clinical reviewer said that Mr Sinclair did not have typical symptoms of lung cancer. His pain and neurological symptoms suggested that the nerves between his spinal cord (neck) and shoulders were being compressed or damaged, which is uncommon in otherwise fit young men. She considered that the advice and medication given to control his pain were appropriate. With hindsight, the delay before further investigation might appear too long when his symptoms were worsening. However, the clinical reviewer noted that, at the time of his diagnosis, Mr Sinclair's tumour was large and advanced, so it was unlikely that an earlier diagnosis would have made any material difference.

33. We are satisfied that prison healthcare staff took appropriate steps to treat Mr Sinclair's symptoms and obtain a diagnosis when there was no improvement. He was appropriately informed of his diagnosis and supported.

Mr Sinclair's medical treatment

34. On 8 August, Mr Sinclair was admitted to hospital with a swollen and painful right arm and finger. (This is sometimes found in people with a pancoast tumour as it can affect lung circulation and oxygenation of blood.) In hospital, Mr Sinclair had a detailed scan and a tumour biopsy. The hospital also assigned a palliative care nurse specialist from a hospice, who liaised with the hospital, prison healthcare staff and directly with Mr Sinclair. On 14 August, Mr Sinclair discharged himself from hospital, against medical advice.

35. On 15 August, the triage nurse created a comprehensive cancer care plan, which she discussed in detail with Mr Sinclair and copied to wing staff. The plan included his involvement and understanding of his condition, access to cancer and palliative care specialists, pain relief and multidisciplinary team reviews. It named a nurse as Mr Sinclair's lead nurse, responsible for coordinating his cancer care in the prison. Prison healthcare staff monitored Mr Sinclair in line with his care plan. They checked him daily and held weekly multidisciplinary reviews. He had further scans and blood tests.

36. On 18 August, a palliative care specialist and a nurse had a long meeting with Mr Sinclair to answer his questions and to discuss issues.

37. On 21 August, the nurse accompanied Mr Sinclair to an appointment with his oncologist, who informed him that he had advanced cancer that was inoperable. The oncologist explained that a combination of radiotherapy and chemotherapy might shrink the tumour, but his life expectancy was likely to be months.

38. On 14 September, Mr Sinclair went to hospital to start radiotherapy and chemotherapy treatment. Due to a recent chest infection, hospital staff decided to delay chemotherapy for a week, but he began radiotherapy, as planned.

39. Mr Sinclair's cancer caused him considerable pain and healthcare staff adjusted his pain relief medication frequently. Prison nurses, GPs, the lung cancer team and the palliative care team often discussed his pain control.

40. On 20 September, the palliative care team advised that Mr Sinclair should be assessed in hospital, as his right arm and neck were swollen, and he had a raised pulse and breathing rate. He returned to Grendon on 23 September, with a plan to begin chemotherapy the next week and to continue radiotherapy.

41. On 27 September, Mr Sinclair had severe stomach pain and difficulty swallowing. A nurse had a long discussion with a nurse at the hospice, who agreed to admit him. The hospice planned to continue active treatment, but would begin end of life care if this was no longer possible. Mr Sinclair said he did not want any further treatment but, on 29 September, after a visit from the nurse, Mr Sinclair agreed to radiotherapy.

42. On 2 October, Mr Sinclair returned to Grendon. Mr Sinclair had agreed with hospice staff that if his heart or breathing stopped he did not want anyone to try to resuscitate him. However, on 5 October, he changed his mind and, on 7 October, a nurse advised staff of this.

43. On 24 October, Mr Sinclair began his last week of planned radiotherapy. He told a prison nurse that he felt tired, but his pain was well controlled. On 31 October, a nurse reviewed Mr Sinclair after officers were concerned about him. He appeared tired and confused. Staff monitored him throughout the day and he was admitted to hospital that evening. The hospital found that the cancer had spread to Mr Sinclair's brain. Mr Sinclair died in hospital on 3 November 2015, from metastatic lung cancer.

44. Healthcare staff at the prison supported Mr Sinclair well throughout his illness and we are satisfied that he received a good standard of care at Grendon, equivalent to that he could have expected in the community.

Mr Sinclair's location

45. Mr Sinclair was a well-established community member, who had lived in the same community at Grendon for some years. Initially he had a first floor cell on D Wing with no integral sanitation. When his condition and mobility deteriorated, he moved to a larger cell on the ground floor with facilities in the cell and where staff could observe him more easily. Buckingham Social Care supplied a hospital type bed, mattress and pillows. During the night, he had a telephone in

his cell, which he could use to contact his palliative care team. Staff considered moving Mr Sinclair to a prison with 24-hour healthcare facilities several times, but he insisted that he did not want to move and wanted to stay at Grendon.

46. Mr Sinclair continued to attend his small therapy group and wing meetings. He received psychological and practical support from other community members, including help to clean his cell, push his wheelchair and collect his meals. Mr Sinclair's supportive relationships with the staff and residents on D wing remained very important throughout his illness. Although the wing was the furthest from the healthcare centre, he did not want to move.

47. Mr Sinclair had spent occasional short periods at the hospice and it was planned he would go there for end of life care. However, his health deteriorated quickly and he died in hospital before staff could arrange a move to the hospice.

48. We are satisfied that staff at Grendon took account of Mr Sinclair's wishes about his location in the prison and his location was appropriate throughout his illness. The clinical reviewer noted that there was no strategy or contingency plans for accommodating end of life care at Grendon. This did not affect Mr Sinclair's care, so we do not make a recommendation, but note that this is something prison and healthcare managers will need to consider for the future.

Restraints, security and escorts

49. When prisoners have to travel outside prison, a risk assessment should determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. The level of restraints used should be necessary in the circumstances and take into account the risk of escape, the risk to the public and factors such as the prisoner's health and mobility.

50. Mr Sinclair attended numerous hospital appointments for scans, blood tests and radiotherapy. Until 25 September, healthcare staff considered he had the ability to escape, so two officers escorted him to appointments. He was handcuffed to one of the officers, always on the left wrist due to the swelling in his right arm. When necessary for treatment, the officer removed the handcuffs.

51. After a multidisciplinary team meeting on 25 September, a senior manager agreed that, due to Mr Sinclair's deteriorating medical condition and poor mobility, restraints were no longer necessary or justified. Two officers continued to accompany him to hospital, but did not use restraints. The officers did not wear prison uniform, except for occasional unexpected and unplanned appointments. We are satisfied that the prison appropriately considered and reviewed Mr Sinclair's risk during his illness.

Liaison with Mr Sinclair's family

52. Prison healthcare staff contacted Mr Sinclair's mother soon after his initial diagnosis and, with his consent, kept her informed about his condition and treatment. On 21 August, after Mr Sinclair's appointment with his oncologist, a nurse immediately told his mother that his cancer was terminal.

53. On 26 August, an officer was appointed as the prison's family liaison officer and phoned Mr Sinclair's mother to introduce herself and offer support. She kept in contact with his family and arranged visits for them. She visited Mr Sinclair in the prison and in hospital.

54. On 3 November, a prison manager informed the officer that Mr Sinclair had died. She went to the hospital that morning to offer condolences and to support his family. She arranged for his family to visit Grendon on 9 November.

55. Mr Sinclair's funeral was held on 24 November. The prison contributed towards the costs, in line with prison service guidance. We are satisfied that the prison appointed a family liaison officer at an early stage, shortly after Mr Sinclair's diagnosis and that his family were offered good support.

Compassionate release

56. 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. On 24 August, after a multidisciplinary team meeting, Mr Sinclair's offender supervisor started an application for compassionate release.

57. On 30 September, the offender supervisor received a report from Mr Sinclair's offender manager (probation officer) supporting the application, after enquiries with his family and that of his victim and establishing that he had suitable accommodation.

58. Despite numerous requests, Mr Sinclair's consultant oncologist, did not provide the required information about his prognosis and life expectancy until 20 October, when she estimated that he might live for up to a year, depending on his response to treatment and fitness for chemotherapy.

59. On 29 October, a senior prison manager submitted the application to the Public Protection Casework Section of the National Offender Management Service for consideration. On 2 November, after Mr Sinclair's condition worsened, the prison received a further opinion from his oncology team in which they gave a life expectancy of only days and the prison forwarded this new information the same day. Sadly, Mr Sinclair died before a decision was reached.

60. We are satisfied that Grendon appropriately considered and processed his application for compassionate release.

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