

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Sansom, a prisoner at HMP Stafford, on 17 February 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 Paul Sansom died of a pulmonary embolism after suffering from pancreatic cancer, while a prisoner at HMP Stafford on 17 February 2016. Mr Sansom was 63 years old. I offer my condolences to Mr Sansom's family and friends.

Mr Sansom had reported back pain for four months, but this was not managed in line with national medical guidelines. Although it was not possible to establish whether his symptoms were linked to his cancer, better management of his back pain might have alerted healthcare staff to the possibility of a serious underlying condition. Although not related to his death, I am also concerned that Mr Sansom was given inappropriate painkillers on various occasions and was not seen urgently by a GP despite being referred by a nurse. Overall, I do not consider that Mr Sansom's clinical care at Stafford was of the standard he could have expected to receive in the community.

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

August 2016

Contents

Summary	
The Investigation Process	
Background Information	
Key Events	
Findings	

Summary

Events

1. Mr Paul Sansom was recalled to prison in October 2012 and had been at HMP Stafford since 27 December 2013. He had a history of chronic lung disease, acid reflux and a peptic ulcer.
2. From the beginning of October 2015, Mr Sansom reported persistent back pain and healthcare staff gave him painkillers, including paracetamol and ibuprofen. On 23 October, a prison GP requested blood tests, which revealed nothing abnormal. Between October and December, Mr Sansom complained of back pain over 20 times. On 17 December, another prison GP examined him and found nothing of concern. Mr Sansom continued to receive painkillers for back pain. On 28 January, he told a nurse that he had been vomiting at night, had lost weight and had very bad back pain. She referred him urgently to a GP, but he did not receive an appointment.
3. On the morning of 5 February, Mr Sansom told wing officers he was not well and could not feel his arm and leg on the left side of his body. A prison GP examined Mr Sansom and called an ambulance, which took him to hospital. Doctors diagnosed a stroke.
4. On 9 February, Mr Sansom moved to another hospital. Three days later, doctors told him he had terminal pancreatic cancer. Mr Sansom's condition deteriorated quickly and he died at 11.20pm on 17 February.

Findings

5. The investigation found that clinical management of Mr Sansom's back pain at Stafford fell below the standard that he could have expected to receive in the community. When he reported back pain, healthcare staff inappropriately advised him to rest, rather than recommending exercise or arranging physiotherapy. They gave him ibuprofen for pain, although this was potentially harmful because of his history of peptic ulcers. Although we cannot know whether Mr Sansom's symptoms were linked to the cancer, better management of his back pain might have alerted healthcare staff to a more serious underlying condition.
6. On 28 January, a nurse listed Mr Sansom for an urgent GP appointment, but he did not see the doctor that day or during the following week. The prison has since revised its appointments protocol to ensure that urgent requests take priority over routine appointments.

Recommendations

- The Head of Healthcare should ensure that healthcare staff manage prisoners with chronic back pain in line with current NICE guidelines.
- The Head of Healthcare should ensure that all prescribing at Stafford is in line with the British National Formulary and staff who issue ibuprofen are aware of the risks to patients with a history of peptic ulcers.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded, who said that the prison found it difficult to give all prisoners their medication in the evening and that they often cancelled hospital appointments.
8. The investigator obtained copies of relevant extracts from Mr Sansom's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Sansom's clinical care at the prison. In his clinical review he made some recommendations not included in this report, which the Head of Healthcare will need to address.
10. We informed HM Coroner for South Staffordshire District of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Sansom's son, to explain the investigation. Mr Sansom's son did not have any specific matters for the investigation to consider.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
13. Mr Sansom's son received a copy of the initial report. He did not make any comments.

Background Information

HMP Stafford

14. HMP Stafford is a medium security prison, which holds more than 700 prisoners across seven wings. Staffordshire and Stoke-on-Trent Partnership NHS Trust provides healthcare services. There are no inpatient facilities. Nurses are on duty daily between 7.45am and 5.30pm and there is a weekday GP service. There is an on-call GP service outside these hours.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Stafford was in February 2016. The report has yet to be published, but inspectors told us that the standard of health services was reasonably good.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its report for the year ending April 2015, the IMB noted that there was an increase in the number of older prisoners with health related problems and long-term conditions. Five-yearly health checks had been introduced for prisoners over 40 years old and annually for those over 50. Additional funding had been used to buy equipment and recruit healthcare assistants, but the GP waiting list had increased significantly and it was not always possible to see everyone on the list within a week. The prison was considering adapting part of a wing, to facilitate end of life care.

Previous deaths at HMP Stafford

17. There have been five deaths from natural causes, at Stafford, since January 2015. There were no significant similarities with the circumstances of those we have already investigated.

Key Events

18. Mr Paul Sansom was recalled to prison in October 2012 and was serving a nine-year sentence for sexual offences. He had been at HMP Stafford since 27 December 2013.
19. Mr Sansom had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), dyspepsia (acid reflux) and a peptic ulcer, which healthcare staff appropriately managed with medication. In 2014, he was treated for high blood pressure, an enlarged prostate and an abnormality in his bladder.
20. On 3 October 2015, Mr Sansom first reported back pain to a nurse, who gave him paracetamol. His back pain persisted and he continued to receive painkillers. On 23 October, a prison GP referred him for blood tests. The results revealed no abnormalities. From October to December, Mr Sansom reported back pain over 20 times, to various nurses. They gave him either paracetamol or ibuprofen and advised him to rest. Mr Sansom also complained of indigestion and received gaviscon to relieve his discomfort.
21. On 17 December, Mr Sansom told a prison GP that his back pain was constant. The GP examined him, but did not find anything of concern. He advised Mr Sansom to continue with ibuprofen and to rest. He noted that if the pain persisted, he would refer Mr Sansom for an X-ray of his spine, but he did not indicate a timescale. Mr Sansom was never referred for an X-ray.
22. Between 10 January and 27 January 2016, Mr Sansom reported back pain six more times. Again, nurses gave him either paracetamol or ibuprofen.
23. On 28 January, a nurse assessed Mr Sansom in his cell as he had vomited during the night. He said he had lost weight recently, had very bad back pain and felt like he had been run over by a bus. She took his basic observations, including his blood pressure, pulse and temperature, which were within the normal limits. She put him on the list to see a GP urgently and noted that his weight should be recorded when he was feeling better. Mr Sansom did not see a GP before he died, as no appointments were available.
24. Nurses gave Mr Sansom more paracetamol for back pain on 29 January and 3 February for back pain.

Events of 5 February

25. At about 8.25am on 5 February, Mr Sansom went to the wing office and told an officer that he was not well. He said he had no feeling in his left arm or leg or the left side of his body. An officer who was also in the wing office walked Mr Sansom back to his cell and helped him into bed. A prisoner care assistant stayed with Mr Sansom while the officer went to get help. The officer went to the wing medical hatch and told two nurses that Mr Sansom was unwell. One nurse went straight to Mr Sansom's cell. The other nurse rang a GP, who went to the cell and examined Mr Sansom. The nurse then asked the communications room to call an ambulance.

26. The communications room requested an ambulance at 8.33am. Paramedics arrived at Mr Sansom's cell at 8.44am and assessed him. At 9.24am, they took him to hospital.
27. Prison staff completed a risk assessment for the hospital escort. A nurse signed the healthcare section, but did not include any information. The Head of Residence assessed that Mr Sansom was low risk and decided that two officers should escort Mr Sansom to hospital but restraints were not required.
28. When Mr Sansom arrived at hospital, he had CT and MRI scans, which revealed several small bleeds in his brain. Doctors diagnosed a stroke and admitted him for observation and additional tests. On 9 February, he moved to the stroke ward of another hospital.
29. On 12 February, a hospital doctor told Mr Sansom that he had terminal pancreatic cancer, with a life expectancy of three months. Mr Sansom apparently took the news well. The escort officers offered him the opportunity to speak to his family.
30. Mr Sansom's condition quickly declined. At 9.55pm on 17 February, a hospital doctor said he was unlikely to survive the next 12 hours. Mr Sansom soon became unresponsive. At 11.20pm, a hospital doctor recorded that he had died.

Contact with Mr Sansom's family

31. On 12 February, after doctors had diagnosed Mr Sansom's terminal cancer, the Head of Residence acted as the prison's family liaison officer. He visited Mr Sansom in hospital that afternoon and discussed contacting his son.
32. Later that day, the Head of Residence tried to contact Mr Sansom's son. There was no answer when he telephoned his mobile number and he no longer lived at the address Mr Sansom had given him. He asked the police for help to locate him.
33. On 16 February, Derbyshire Police managed to contact Mr Sansom's son and told him that Mr Sansom was seriously ill in hospital. His son then telephoned the prison. The Head of Residence explained his role and updated him about Mr Sansom's condition. He gave him the contact number for the hospital so he could speak to the hospital staff for more information.
34. At 10.05pm on 17 February, the prison's duty manager told the Head of Residence that Mr Sansom was likely to die that evening. He tried to contact Mr Sansom's son several times, but was unable to speak to him before Mr Sansom died. He eventually informed Mr Sansom's son of his death at 8.30am on 18 February. He offered his condolences and support and kept in contact with him.
35. Mr Sansom's funeral was held on 9 March. The prison contributed to the costs, in line with national instructions.

Support for prisoners and staff

36. After Mr Sansom's death, the Head of Residence debriefed the escort officers. He offered his support and that of the staff care team.
37. The prison posted notices informing other prisoners of Mr Sansom's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Sansom's death.

Cause of death

38. The coroner accepted the cause of death provided by the hospital consultant, who recorded that Mr Sansom had died from a pulmonary embolism (a blockage in the artery that carries blood from the heart to the lungs), with pancreatic cancer as an underlying cause. Ischaemic stroke was a contributory factor.

Findings

Clinical care

Treatment of Mr Sansom's back pain

39. Mr Sansom complained of back pain over 28 times between 3 October 2015 and his admission to hospital on 5 February. Throughout this time, nurses gave him basic pain relief and advised him to rest. Prison GPs examined him twice, but found no serious cause for the pain. A GP suggested an X-ray of his spine if the pain did not subside, but did not indicate a timescale and there was no evidence of such a referral.
40. The clinical reviewer said that, according to National Institute for Health and Care Excellence (NICE) guidelines, X-rays to investigate low back pain are considered inappropriate. The general advice from healthcare staff that Mr Sansom should rest was incorrect and suitable exercise, or a referral for physiotherapy, would have been more appropriate.
41. The clinical reviewer noted that pancreatic cancer is very difficult to diagnose. While there is no clear evidence that his symptoms of back pain between October 2015 and January 2016, were caused by the cancer, it is possible that the back pain was a symptom. Better management of the back pain might have alerted healthcare staff to the possibility of a more serious underlying condition or cause. The clinical reviewer considered that the management of Mr Sansom's back pain was below the standard expected in the community. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff manage prisoners with chronic back pain in line with current NICE guidelines.

Medication

42. Nurses and GPs frequently gave Mr Sansom ibuprofen for his back pain. As he had a history of peptic ulcers, the use of ibuprofen was potentially harmful, as it could have caused another peptic ulcer to develop. While taking ibuprofen, Mr Sansom had symptoms of indigestion but rather than stopping it, healthcare staff prescribed gaviscon to treat the indigestion. It is surprising that a number of nurses and GPs inappropriately prescribed ibuprofen and this contributed to Mr Sansom's care being below the standard he might have expected. We make the following recommendation:

The Head of Healthcare should ensure that all prescribing at Stafford is in line with the British National Formulary and staff who issue ibuprofen are aware of the risks to patients with a history of peptic ulcers.

Delay in seeing a GP

43. On 28 January, a nurse put Mr Sansom on the list to see a GP urgently after he complained of vomiting, losing weight and severe back pain. However, no appointments were available and he still had not seen a GP before his stroke on 5 February. The clinical reviewer indicated that an urgent appointment should have taken place within 24 hours and the handling of this was again below the

standard expected in the community. Although a GP review would not necessarily have prevented the stroke, Mr Sansom had concerning symptoms and should have been seen quickly. Since his death, the Head of Healthcare has changed the protocol for managing appointments so that when there are no available appointments, an urgent appointment would take the place of a routine appointment. This change should prevent a recurrence of this problem when prisoners need an urgent GP appointment. We therefore do not make a recommendation.

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