

**Investigation into the circumstances surrounding the  
death of a man on 15 November 2008, whilst in the custody  
of HMP & YOI Holme House**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**September 2009**

This is the final report of an investigation into the circumstances surrounding the death of a man on 15 November 2008. The man, who was aged 63, died at the Butterwick Hospice, Stockton on Tees, whilst in the custody of HMP Holme House. He died from cancer of the lungs and liver, which had probably spread from his colon.

He had arrived at Holme House on 22 October, and was moved there from HMP Acklington (where he had been since October 2001) because he needed 24 hour nursing care which Acklington could not provide. The man was imprisoned for life in 1970. The Parole Board had considered his release on licence many times, but his applications were always refused. He spent some time in the early 1990s in an open prison, but for most of his sentence he was held in category C training prisons around the country. His family circumstances were such that he had no next of kin, his only friends being people he knew in prison. At the time of his death, he had spent 38 years in custody.

One of my investigators conducted the investigation. I am grateful to the doctor for conducting the clinical review on behalf of North Tees Primary Care Trust. I would also like to thank the Governor of Holme House, and the Governor of Acklington, and their staff for their co-operation during this investigation. The issuing of this report and the draft report had been delayed for which I apologise.

I make one recommendation and note one area of good practice within my report.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**September 2009**

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## **SUMMARY**

In 1970, the man and his wife were convicted and sentenced to life imprisonment. (His wife died in the late 1990s whilst in prison.) In 2006, the man developed cancer of the stomach. He was treated successfully by means of surgery and chemotherapy. In September 2008, whilst he was at HMP Acklington, he was diagnosed with an untreatable recurrence of cancer, this time within his colon and elsewhere in his body. He was treated in hospital until 8 October when he returned to prison for palliative care.

The man stayed at HMP Acklington for a further three weeks, and was then moved to HMP Holme House which can provide 24 hour nursing care. He moved to North Tees General Hospital on 4 November and then to the Butterwick Hospice on 11 November where he died on 15 November aged 63.

## THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of my investigators, who first visited HMP Holme House on 27 November 2008 when he was shown around the prison and given access to the man's prison records. My investigator met members of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor the day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on their prison.) Neither the IMB nor the POA had any specific matters to bring to my investigator's attention at the time. Whilst on this visit, my investigator had an informal discussion with a member of the prison nursing staff, who had known the man in the brief time he was at Holme House.
2. My investigator also visited Butterwick House, the hospice where the man died, and reviewed relevant records held there. He was shown the room where the man died, and it was agreed that the clinical reviewer could receive copies of clinical notes relating to the man's care should he wish.
3. North East Offender Commissioning Unit (NEOCU) was asked by the North Tees Primary Care Trust to undertake a clinical review of the care the man received while he was in custody. A doctor carried out the review on their behalf. My investigator asked the doctor to judge specifically whether the care afforded the man was of an equivalent standard to what might have been expected for a terminally ill man who was not in custody.
4. One of my Family Liaison Officers, was appointed as the contact point for the man's friends and family, but to date no next of kin have been identified.
5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem and the toxicology reports. He was told that, because the man died in a hospice and his death was expected, a post mortem did not take place. Upon completion, a copy of my report will be sent to the Coroner to assist his enquiries into the circumstances surrounding the man's death.

## **HMP & YOI HOLME HOUSE**

6. Holme House is a purpose built category B local prison that holds up to 994 men from the ages of 17 upwards from the North Tees and Durham areas. It was opened in 1992 and has been run by the Prison Service under a Service Level Agreement since 2005. The prison provides 24 hour nursing cover with a 28 bedded in-patient unit which has both single and double occupancy rooms.
7. Dame Anne Owers, Her Majesty's Chief Inspector of Prisons, carried out an unannounced inspection of Holme House in April 2005. Her report says that the provision of healthcare services is achieved through a 'well qualified, experienced and committed healthcare team'.
8. The Independent Monitoring Board annual report for 2006-07 (the latest available) says that, although there have been staff shortages in healthcare the nursing staff and others in healthcare have shown great compassion and dedication in their work'.
9. There have been six deaths due to natural causes at Home House since I first started investigating all deaths in prison custody in 2004. None of my previous investigations involved circumstances similar to this one.

## **HMP ACKLINGTON**

10. HMP Acklington is the most northerly prison in England and opened in 1972 as a category C prison. The jail is situated on a former RAF station near Amble in Northumberland. It has the capacity to house 946 prisoners.
11. The healthcare department is run by Northumberland Primary Care Trust. Nurses and a prison doctor (provided through a local practice) deliver primary healthcare during the daytime, seven days a week. There is no out of hours medical cover at the prison, although a doctor can be contacted by prison staff over the telephone after 6.00pm. Prisoners with long-term medical conditions who might require in-patient or 24 hour nursing care are transferred to an outside hospital or another prison.
12. Her Majesty's Chief Inspector of Prisons last reported on Acklington following an announced inspection in December 2006. Dame Anne was disappointed at what she found at Acklington, and concluded that it did not provide a safe and decent environment. Although healthcare had looked up in recent years, she thought that there was room for further improvement.
13. The Independent Monitoring Board's Annual Report for 2007-08 recognised that improvements had been made within the prison as part of the Performance Improvement Plan (PIP) that was ongoing throughout 2007. However, members of the board remained critical of much of the older living accommodation within the prison, saying that sanitation was poor and the showers worked intermittently or were out of use for prolonged periods.

14. At the time of the man's death there had been 11 previous deaths from natural causes at Acklington since I became responsible for investigating all deaths in prison custody in 2004. There are no similarities between the findings and recommendations made in this report and those following my earlier investigations.

## KEY FINDINGS

15. The man was convicted of murder in July 1970. He was sentenced to life imprisonment plus ten years concurrent for sexual offences, with a recommendation that he serve a minimum of 20 years.
16. He was originally held in HMP Wormwood Scrubs before being transferred to HMP Durham and then to HMP Wakefield. He arrived in Wakefield in July 1971 and spent the next eight years there. He was subject to reviews by the Lifer Review Board throughout his time at Wakefield and HMP Maidstone, where he transferred in June 1981, after spending a brief time in HMP Hull. (This meant that annual reports were carried out on him whilst he was in prison.) He was described by staff as being a very quiet, timid individual, who was easily led. He spent much of his time on (what was then) Rule 43 which meant that he was segregated at his own request from the general prison population on a special wing to ensure his safety.
17. The Parole Board considered his case in 1987 and recommended that he should transfer to a category C training prison. After being transferred first to HMP The Verne and then to HMP Channings Wood, he arrived at HMP Featherstone in September 1989.
18. In 1992, the Parole Board recommended that he should be prepared for release once he had served a suitable time in open conditions. He was transferred to HMP Leyhill in January 1993. However, in February 1994 he was transferred back to closed conditions because he was found in possession of material that questioned his suitability for release. After the decision was reviewed, he was transferred to HMP Lindholme in July 1994.
19. Because of this incident, and the fact the Prison Service now targeted offending behaviour through specific offending behaviour programmes, he was recommended for the Sex Offenders Treatment Programme (SOTP) to help reduce the risk he posed to the public. He accepted the recommendation and transferred to HMP Dartmoor in August 1995 for assessment of suitability for the SOTP. He returned to Lindholme shortly afterwards, pending a suitable placement for him on an SOTP course.
20. In January 1996, he arrived at HMP Wayland and asked that future parole reviews be postponed until he had completed his SOTP course. At around this time, his wife died whilst in custody at HMP Cookham Wood.
21. The man's 1999 Parole Board report says that he had undergone two core SOTP programmes and that intensive one to one work should be the focus of future offending behaviour work. His behaviour whilst at Wayland was described as good, he was not a control problem, and had not been the subject of any disciplinary reports. The report went on to say:

'Due to his lack of self-confidence and shyness the man found it difficult to mix with other inmates, instead preferring his own company. He held two jobs working in the Tailors' shop during the day, and the

Plastics shop in the evening. Instructors reported that he was hard working.'

22. The Parole Board recommended in December 1999 that he should complete the adapted SOTP before being considered for release. He undertook this course at HMP Usk, but it was subsequently recommended that he retake the course at another prison.
23. In September 2001, he was diagnosed with diabetes for which he was originally prescribed tablets to help control his sugar levels. In October 2001, he transferred to Acklington.
24. On 21 March 2006, the man was diagnosed with stomach cancer. He was operated on at Royal Victoria Infirmary, Newcastle upon Tyne, on 7 November of the same year. The doctors removed part of his stomach and followed the surgery with chemotherapy treatment. Whilst receiving chemotherapy at Newcastle General Hospital on 23 June 2007, he suffered a heart attack.
25. He was thought by the Parole Board in June 2008 to be suitable for category D (open conditions), but the Secretary of State decided that he should remain in closed conditions in order to complete another offending behaviour programme.
26. On 6 August 2008, he was seen by the visiting prison doctor at Acklington, because he had been complaining of feeling generally unwell for the previous three days. The doctor asked for blood tests to be carried out. The man was seen again on 8 August when he was feeling a lot better. However, because his blood tests were 'inconclusive', the visiting prison doctor asked for retests. The doctor instructed that, should the new blood tests show anything abnormal, the man was to be referred to Wansbeck General Hospital for a general medical opinion. The prison medical officer, wrote a referral letter to a consultant surgeon at Royal Victoria Infirmary, on 28 August. However, the man was not seen in clinic again until 24 September when he was assessed by a visiting eye specialist because of his declining retinal function (a condition not uncommon in diabetics).
27. He was seen on 24 September by the clinic nurse who spoke with the clinic doctor to arrange that he should be seen the following day at the morning clinic. On 25 September, the man was seen by another clinic doctor who arranged for him to be admitted to Wansbeck General Hospital under the care of the establishment's specialist doctor.
28. The specialist doctor arranged x-rays and ultrasound investigations. It emerged from the tests that the man might have cancer. A computerised tomography (a CT scan which is a form of x-ray) showed that his liver was 'riddled with metastasis' and that the cancer might have spread elsewhere in his body. Further tests by the specialist doctor showed that the primary (main) source of the man's cancer was probably his colon and that the cancer had spread extensively throughout his body.

29. He went back to Acklington on 8 October. The cancer was untreatable and he was to receive palliative care to control his symptoms. He was seen again by the clinic doctor, and they discussed his care. The man understood that he had a terminal illness and told the clinic doctor that he wanted to stay at Acklington for 'as long as possible'. Healthcare staff at Acklington, were guided by their 'Care of the Dying Pathway' policy document. This meant that the man was seen every day by somebody from the healthcare department and they were advised by the community palliative care team.
30. A multi-disciplinary case conference was held on 21 October which was attended by healthcare and discipline staff. It was the clinic doctor's view that the man should transfer to a prison with 24 hour nursing care as soon as possible. Accordingly, on 22 October 2008 he transferred to Holme House.
31. The man was cared for by healthcare staff at Holme House until 4 November when he was admitted to North Tees General Hospital pending a place becoming available at a local hospice. When he initially arrived at the hospital, prison staff were under instruction, that he should be restrained using handcuffs. However, after only one day, these restraints were removed. On 11 November, he was moved to the Butterwick Hospice (which is on the same site as the General Hospital), again with no restraints. He died there on 15 November 2008.
32. The staff who were present at the time of his death were called back to the prison and given support via the staff care and welfare services. A hot debrief was also held. It was known that he had no contact with any relatives, but efforts were still made to try and identify anyone who could be considered as next of kin.

## ISSUES

### The care provided by HMP Holme House

33. Despite the man's short time at Holme House, and because he was terminally ill, the prison staff made extensive enquiries to identify his next of kin. He had spent the last 38 years in prison. He had no children of his own. His wife had died in 1997 and the only people he had contacted by letter or telephone over the past few years were former prisoners and professionals such as solicitors. The prison's Deputy Governor, therefore asked the local police to use their contacts to try and trace any next of kin, but it was all to no avail.
34. Holme House also gave fair and balanced consideration to the use of restraints on him. On 5 November, after he had been in hospital for just one day, the restraints were removed from him. Having reviewed the notes made by staff whilst he was in the hospital and later at the hospice, I believe that the staff were kind, courteous and helpful in many ways. The man became quite a difficult man as a consequence of his illness, and required constant nursing help for all his daily needs. It appears from the bedwatch log that staff would help with some of these tasks when they felt able.

**I would ask the Governor to commend the care and compassion shown by the staff of Holme House towards the man at this very difficult time of his terminal illness.**

### Clinical care

35. The clinical reviewer, has considered the request by the prison doctor, on 8 August that the man should have his blood tested. The clinic doctor had instructed that, in the event of any abnormalities, the man was to be referred to Wansbeck General Hospital. This instruction was not carried out properly. Indeed, there does not appear to be any evidence that the second set of results was actually received. There is, however, a letter of referral dated 28 August to a consultant surgeon at the Royal Victoria Infirmary in Newcastle, by the prison medical officer. The referral says that the man has a history of having had recent blood results that show his ESR (erythrocyte sedimentation rate – which is indicative of inflammation within the body, perhaps because of an infection or the presence of a cancer) as being raised.
36. However, it does not appear that he was actually assessed by healthcare staff from 8 August until 24 September when he was seen by the clinic nurse. When another prison doctor, saw the man the next morning, he arranged immediate admission to the hospital via an emergency ambulance. It was shortly after his emergency admission that he was diagnosed with the terminal cancer which eventually led to his death. The Clinical Reviewer makes it clear in his report that he does not think this delay affected in any way 'the prognosis of the man's terminal condition'. He judges that it was a 'minor concern'. In other words, the man's cancer was well established by the time he saw the clinic doctor on 6 August. Nevertheless, I am concerned that

the systems appear to have failed, resulting in a doctor's clear instructions not being carried out.

**The head of healthcare at HMP Acklington, in conjunction with Northumberland Care Trust, should ensure there are robust systems in place so that tasks requested by medical staff in respect of patient care are fully and promptly carried out.**

37. The man was in prison for nearly four decades. He developed diabetes during that time and survived one earlier episode of cancer in 2006. Unfortunately, he developed cancer again in 2008 and it was not identified on this occasion until it had spread widely throughout his body.

## **CONCLUSION**

38. The man did not have any known family, and his only friends were those around him in prison. He expressed a desire to remain at Acklington as long as possible during the last stages of his life. Acklington were able to do this to a point, but there came a time when he needed full time nursing care which the prison was not equipped to provide. He was therefore transferred to Holme House and thereafter to a hospital and hospice in the Newcastle area. I believe that both Holme House and Acklington looked after him with compassion and skill.

## **RECOMMENDATIONS**

The Prison Service accepted the following recommendation:

The head of healthcare at HMP Acklington, in conjunction with Northumberland Care Trust, should ensure there are robust systems in place so that tasks requested by medical staff in respect of patient care are fully and promptly carried out.

## **GOOD PRACTICE**

I would ask the Governor to commend the care and compassion shown by the staff of Holme House towards the man at this very difficult time of his terminal illness.