



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in August 2013
at Skegness and District General Hospital, while a
prisoner at HMP North Sea Camp**

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 on 11 August 2013 a prisoner at HMP North Sea Camp. The man, who was 62 years old, died of bronchopneumonia at Skegness and District General Hospital. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A clinical reviewer conducted a review of the man's clinical care at the prison.

The man was sentenced to life imprisonment in 1985 and transferred to an open prison, HMP North Sea Camp, in October 2011. He had suffered from a severe respiratory condition for a number of years and his health had deteriorated to the extent that he was reliant on an electric wheelchair by the time he arrived at North Sea Camp. The man was frequently admitted to hospital with shortness of breath and chest infections. On 9 August 2013, his health declined significantly and he was admitted to the palliative care unit at Skegness and District General Hospital, where he died two days later.

Although North Sea Camp was not an ideal location for the man, I agree with the clinical reviewer that the care he received at the prison was of an equivalent standard to that which he could have expected in the community. The investigation found that palliative care at the prison was underdeveloped but I agree with the clinical reviewer, that this was not detrimental to the man's clinical care.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2014

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SUMMARY

1. The man was sentenced to life imprisonment in 1985. He transferred to HMP North Sea Camp, an open prison, from HMP Wymott in October 2011.
2. The man arrived at North Sea Camp with severe COPD (Chronic Obstructive Pulmonary Disorder – a term used to describe a number of lung diseases) and due to his condition he used an electric wheelchair. The move occurred despite the reservations of healthcare staff at North Sea Camp and the disability liaison officer at Wymott about the ability of the prison to cope with the man's needs.
3. When it later became clear that it would be difficult for North Sea Camp to meet the man's healthcare needs, efforts were made to transfer him to prisons with more appropriate facilities, but no other prison was prepared to accept him.
4. Healthcare staff at North Sea Camp looked after the man well. He was referred to relevant specialists and was taken to hospital on a number of occasions for treatment when his COPD became worse.
5. In October 2012, a meeting was held to examine how palliative care could be provided at North Sea Camp and the man's case was discussed. From January 2013, palliative care staff from the local hospice became involved in his care but there was no overarching palliative care plan.
6. In February 2013, a Parole Board hearing recommended that the man should be assessed in a nursing environment with a view to potential release. The placement at a local hospice started in the middle of February, but in early March the man returned to the prison after nurses alleged he had behaved inappropriately. A further Parole Board review was planned but did not take place before the man's death.
7. The man's health continued to deteriorate and on 9 August, he was moved to the palliative care unit of a local hospital. He died there on 11 August.
8. Although North Sea Camp was not the most suitable location for the man we are satisfied that ultimately staff at the prison managed to provide care of an equivalent standard to that which he could have expected in the community. We make two recommendations about the implementation of palliative care plans at an appropriate stage and allocating prisoners with significant health needs to suitable prisons.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.
10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
11. The investigator contacted North Sea Camp and obtained copies of the man's prison medical records and relevant aspects of his general prison records. The investigator and clinical reviewer interviewed five members of staff at the prison on 12 November 2013. The investigator wrote to the Governor with preliminary feedback
12. HM Coroner for South Lincolnshire was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent this report.
13. Despite the best efforts of the prison, the Coroner's office and this office, the man's next of kin could not be traced.
14. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section

HMP NORTH SEA CAMP

15. North Sea Camp is an open prison for category D prisoners near Boston in Lincolnshire. (Open prisons are for those who can be reasonably trusted not to try to escape.) The prison holds over 400 sentenced male prisoners in six residential units. Prisoners who are assessed as suitable are able to work in the community, either as community service volunteers or in paid work.
16. Health services at the prison are provided by Lincolnshire Partnerships NHS Foundation Trust. The healthcare centre is open from 7.30am to 6.00pm Monday to Friday and 7.30am to 12.15pm at weekends. There are four GP sessions a week and a number of clinics for life long conditions, including a clinic for prisoners with chronic respiratory conditions.

HM Inspectorate of Prisons

17. An inspection of HMP North Sea Camp in May 2013 found that the prison fulfilled its core function relatively successfully and that there had been some improvements in the standard of health services. The Inspectorate reported that there were no care plans for prisoners who required them, such as those with disabilities or palliative care needs. They had previously recommended that the prison develop an older prisoner policy, but this was still not in place at the time of the inspection.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its latest published annual report for 2011/12, the IMB was concerned about the prison's ability to care for older and terminally ill prisoners without 24 hour healthcare services. The IMB reported that the prison was working with social care providers in Lincolnshire including, Marie Curie, Macmillan and St Barnabas Hospice. However, the IMB was concerned that accommodation was not appropriately adjusted for older, disabled and terminally ill prisoners.

Previous deaths at HMP North Sea Camp

19. The man's is the fourth death we have investigated at North Sea Camp since 2012. There are no similarities with previous reports.

KEY EVENTS

20. On 5 June 1985, the man was sentenced to life imprisonment for serious sexual offences and sent to HMP Wakefield. He smoked and refused to give up smoking, despite encouragement by prison staff to participate in a smoking cessation programme. Between 1987 and 2004 he was an inpatient at a medium secure mental health unit. He was diagnosed with COPD in 1996 and his health continued to decline over the years to such an extent that he needed to use an electric wheelchair. In November 2010, the man was at HMP Wymott, when the Parole Board recommended he should transfer to an open prison as part of his preparation for release.
21. By November 2010, the man had severe COPD and the Head of Healthcare at Wymott had approached a number of open prisons including North Sea Camp to see if they could meet the man's health needs. Every prison said they would not be able to accommodate the man.
22. On 4 January 2011, North Sea Camp said that the prison would be unsuitable as the man would find it hard to negotiate the large site, even with an electric wheelchair. The Head of Healthcare and a nurse explained that getting to the healthcare unit involved getting round a working farm and even getting his own meals might be difficult. An undated report by the disability liaison officer at Wymott, suggested that North Sea Camp was not a suitable location for the man, including the fact that it did not offer 24 hour healthcare. (No open prisons have 24 hour healthcare.)
23. In July 2011, the man's solicitors wrote to the National Offender Management Service (NOMS) because they were concerned about the length of time it was taking to move the man to an open prison. As a result the national Prison Population Management Unit eventually persuaded the Governor of North Sea Camp to accept the man.
24. North Sea Camp liaised with Wymott about the man's needs before he transferred. However, when he arrived at North Sea Camp on 3 October, healthcare staff were surprised at the severity of his condition and were concerned that his escort was a nurse rather than an officer.
25. On his first night at North Sea Camp, a nurse noted the man's respiratory problems and mobility issues. Over the next few days, the man told officers that he was concerned he had no call bell in his cell and he had had trouble getting to the toilet during the night. He was given a personal alarm and allocated a 'buddy' to help him. (A 'buddy' is another prisoner who helps fellow inmates with daily living activities.) The man was also assigned a named nurse with experience of respiratory conditions.
26. On 4 October, one of the prison GPs recorded that North Sea Camp was not a safe environment for the man because of his severe COPD and concerns about his heart. He referred him to a respiratory physician and a cardiologist. The man said that he did not want to ask for a transfer to another prison because he felt it would impact negatively on his chances of release.

27. On 6 October, the head of healthcare disability officer noted that although the man was registered as disabled and had some difficulties managing certain things, he could manage his own medication and look after himself. Later that day, he was taken to hospital with chest and back pains but was discharged the next day.
28. On 1 November, the man was taken to hospital, because his COPD had got worse (known as an exacerbation). He was prescribed antibiotics and discharged the same day.
29. On 16 November, a prison GP, noted that the man was inappropriately placed at North Sea Camp, because he required 24 hour social care with significant nursing input which was not available at the prison. She considered that he was a palliative care patient and had stage 4 COPD but there was no formal palliative care plan. (Stage 4 is the most severe stage of the disease, also known as end stage.)
30. On 18 November, the Head of Healthcare contacted HMP Lincoln to see if the man could be transferred there. However they said that they were unable to take him as their one cell for a prisoner with disabilities was already occupied.
31. On 19 November, the man was admitted to hospital again for two days with another COPD exacerbation. On 21 November, the nurse contacted HMP Leicester to discuss transferring the man, but they said they were full. HMP Nottingham said that their enhanced care cells were in a location that would make the man vulnerable and HMP Whatton said that he did not fit their palliative care criteria.
32. Over the next few months, the man was admitted to hospital several times, and staff at North Sea Camp continued to care for him on his return to prison.
33. On 19 April, the Governor and healthcare staff had a meeting about the possibility of release on compassionate grounds for the man. They concluded that it was unlikely this would be granted. They did not record the reason for that conclusion and no application was made. All agreed that they could only try to make his as comfortable as possible at North Sea Camp.
34. On 1 June 2012, Respiratory Services for Lincolnshire Community Health Services suggested that North Sea Camp was not suitable for the man's needs, and recommended that he should be moved to a warden-controlled environment.
35. On 28 June, HMP Norwich was asked if the man could have a place in their palliative care wing. Norwich refused, and said the unit only accepted patients who were from the Norwich area and still had family in the area.
36. The records show that three care plans were opened while the man was at North Sea Camp – one to ensure that physical observations were completed, one to promote mobility and prevent complications and another where the

care goal is not specifically defined. There was no specific palliative care plan.

37. On 2 October 2012, a meeting was held to discuss how the Gold Standards Framework (a palliative care framework used for patients nearing the end of their life) could be implemented at North Sea Camp and how it might be used for those prisoners affected, including the man. The Governor, the head of healthcare other healthcare staff and Macmillan nurses attended the meeting. The head of healthcare said that a nurse palliative care specialist had agreed to work with North Sea Camp to help them provide appropriate care. The man's case was specifically discussed. It was recorded that he needed two full time buddies to help with his nebuliser and other daily living requirements but no comprehensive palliative care plan was implemented.
38. On 3 January 2013, the nurse contacted St Barnabas Hospice, Lincoln and they agreed to assess the man. On 7 January, staff from the hospice visited and agreed to come to the prison twice a week to assist the man with his needs. On 11 January, they confirmed this in writing and indicated that the man would be offered a bed at the hospice towards the end of his of his life
39. On 8 February 2013, a Parole Board hearing concluded that, subject to appropriate accommodation, the man should be released. The Parole Board wanted to establish whether a hospice or a nursing home in the Lincoln area would most suit his needs.
40. On 14 February, the man was released on temporary licence to St Barnabas Hospice. While he was there, hospice staff made a number of allegations that the man had made inappropriate requests for personal care. He returned to North Sea Camp on 6 March and St Barnabas Hospice staff continued visiting the man in prison.
41. The Parole Board reviewed the man's case on 4 June 2013. The Board asked his offender manager to submit a report and for the man's solicitor to make representations by 1 July 2013, when the Board would decide whether to review the decision taken in February.
42. The man's offender manager, submitted a report to the Parole Board that did not support release, although she did not consider his risk had increased or decreased since her previous report, when she considered that he was a medium risk. No further Parole Board decision was taken before the man died.
43. The man continued to go to hospital frequently as a result of his COPD and his condition continued to deteriorate. On 9 August, a doctor saw the man in his cell and decided that he was too sick to be cared for at North Sea Camp any longer. The man was released on temporary licence the same day to a palliative care bed at Skegness District and General Hospital, where he died on 11 August 2013.

Support for staff and prisoners

44. Despite repeated requests, the prison has not informed us how prisoners and staff were told of the man's death and whether any support was provided. Healthcare staff told the investigator that they were not informed of the funeral details although some of them had wished to attend, particularly as the man was not in touch with his family. A residential governor attended the funeral which the prison arranged and funded.

Post-mortem Report

45. The cause of death given on the post-mortem report, was

1a: Bilateral Bronchopneumonia,
2b: Chronic Obstructive Pulmonary Disease,
2: Coronary Artery Sclerosis and Smoking.

ISSUES

Clinical care

46. The clinical reviewer concludes that the care the man received at North Sea Camp was of an equivalent standard to that which he could have expected in the community. Although healthcare staff were surprised at how ill the man was when he arrived at the prison, the clinical reviewer considers that the team at North Sea Camp managed his condition well.
47. We are satisfied that staff did their best to manage a challenging situation. Good efforts had been made to prepare for the man's arrival including installing an oxygen concentrator in his cell. After he arrived, the man was assigned a named nurse who had experience in dealing with patients with respiratory conditions. He was given a personal alarm and allocated a buddy to help with daily living tasks. He saw healthcare staff frequently and was referred to appropriate specialists when required.

Palliative care

48. Palliative care is the term used to describe the care that is given when a cure is not possible. It can be used for those diagnosed with cancer and non-malignant diseases such as respiratory disease or heart failure. It is a proactive approach involving a multi-professional team with regular care planning and reviews with the patient. As well as controlling pain and other distressing symptoms, it should cover the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.
49. The man was being treated as a palliative care patient at HMP Wymott, yet palliative care was not discussed until a year after he arrived at North Sea Camp. The Head of Healthcare told the investigator that he did not know the Gold Standard Framework (a palliative care framework) could be used in prisons, which caused the delay. There was a multidisciplinary meeting in October 2012, when the use of the Gold Standard Framework was discussed, but it was not until January 2013 before the prison consulted a hospice about the man's care. Once he was assessed, hospice staff visited the man frequently.
50. Although there were at least three care plans in place for the man after he arrived at North Sea Camp, none of these covered his palliative care. The clinical reviewer considers that formal palliative care plans should have been initiated. While this does not appear to have had any detrimental effect on the clinical treatment the man received, it would have improved the co-ordination of other aspects of his care.
51. We are pleased the prison has now adopted the Gold Standards Framework. However, it is important that palliative care plans are put in place as early as possible for those recognised as terminally ill. We make the following recommendation:

The Head of Healthcare at North Sea Camp should ensure that a palliative care plan is initiated for all prisoners who are recognised to be terminally ill.

The man's location

52. After the Parole Board recommended, and it was agreed, that the man should be transferred to open conditions, his solicitors, understandably, pressed for the transfer to happen. Unfortunately, there are no open prisons with 24 hour health cover. After initially refusing, North Sea Camp agreed to take the man after being contacted by the Prison Service Population Management Unit. However, it would seem that healthcare staff did not expect his level of need to be as great as it was. There were several references in the records to North Sea Camp not being suitable for the man and staff tried on a number of occasions, without success, to arrange for him to be moved to a prison with more comprehensive healthcare facilities.
53. Despite the evident difficulties, it is clear that healthcare staff at North Sea Camp did a good job looking after the man. However, we agree that North Sea Camp was not an ideal location for the man and he should have been transferred to a prison within the East Midlands area with more appropriate facilities particularly once his health deteriorated further. We make the following recommendation:

The Deputy Director of Custody for the East Midlands should ensure that prisoners with significant health needs which can no longer be met at North Sea Camp are transferred to other suitable prisons.

RECOMMENDATIONS

1. The Head of Healthcare at North Sea Camp should ensure that a palliative care plan is initiated for all prisoners who are recognised to be terminally ill.
2. The Deputy Director of Custody for the East Midlands should ensure that prisoners with significant health needs which can no longer be met at North Sea Camp are transferred to other suitable prisons.

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 at North Sea Camp should ensure that a palliative care plan is initiated for all prisoners who are recognised to be terminally ill.	Accepted	The Head of Healthcare in conjunction with the Governor at HMP North Sea Camp will introduce arrangements whereby a palliative care plan is initiated for all prisoners who are recognised to be terminally ill. This arrangement will be fully supported by the Prison and will include accommodation, support and services assessed to best suit prisoners recognised as terminally ill.	31 May 2014 Head of Healthcare & Governor	Head of Healthcare Head of Residence & Services
2	The Deputy Director of Custody for the East Midlands should ensure that prisoners with significant health needs which can no longer be met at North Sea Camp are transferred to other suitable prisons.	Accepted	The Governor of HMP North Sea Camp will on behalf of the Deputy Director of Custody for the East Midlands ensure that prisoners with significant health needs which can no longer be met at North Sea Camp are transferred to other suitable prisons.	28 February 2014 Governor (On behalf of DDC East Midlands)	Head of Residence & Services