PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Brixton in October 2013

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 of a man, who died in October 2013 at HMP Brixton. He was 68 years old. The man died as a result of cancer of the oesophagus. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Brixton. The prison cooperated fully with the investigation.

The man was sentenced to four years imprisonment in May 2012 and was transferred to HMP Brixton in June 2013. He had mouth cancer before he came to prison and reconstructive jaw surgery was planned. On 9 September, he reported to a nurse that he had pains in his waist area. A prison GP saw him quickly and referred him to hospital for further tests. The hospital diagnosed widespread secondary cancer. Tests later indicated that the primary cancer was of the oesophagus, but an administrative error at the prison meant that the man was not taken to a hospital appointment which would have confirmed this. He died suddenly and unexpectedly before the appointment could be rearranged.

Overall, the clinical reviewer is satisfied that the clinical care the man received in Brixton was equivalent to that he might have expected in the community. However, I am concerned that the man missed an important hospital appointment through an administrative error and that restraints were applied unnecessarily during appointments towards the end of his life. Although, it did not affect the outcome for the man, the investigation also found that the prison's emergency response procedures were deficient, resulting in a delay in calling an ambulance.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man was sentenced to four years in prison in May 2012 and was sent to HMP High Down. He transferred to HMP Brixton in June 2013.

2. The man had a history of mouth cancer, chronic obstructive pulmonary disease (COPD – lung disease) and cataracts. On 9 September, the man told a nurse that he had a pain in his waist. As a result, a prison GP examined him the next day. Blood test results were abnormal and, on 12 September, another prison GP referred him urgently to a hospital specialist for suspected cancer.

3. After a range of tests, hospital specialists diagnosed widespread secondary liver cancer on 7 October. The primary site, and therefore a definite prognosis, was not known at the time.

4. The man had hospital appointments on 16 and 17 October. The security risk assessments for the escorts were out of date and resulted in the man being assessed and restrained as a risk of escape, although he was reliant on a wheelchair at the time. The man missed an appointment for an endoscopy on 24 October because of an administrative error at the prison. .

5. On 18 October, a meeting was held to discuss the possibility of compassionate release and the Head of Healthcare, began to research potential hospice placements. In the meantime, the man continued to share a cell on the second floor landing. He declined to move to the ground floor.

6. The man was well cared for at the prison and a nurse visited him in his cell every day. His cellmate helped him with many day to day tasks and wing staff were also involved in caring for him.

7. On 27 October, an officer was talking to the man's cellmate in their cell when she noticed the man suddenly stop breathing. She called an emergency code and attempted resuscitation. The control room did not call an ambulance until after a nurse arrived at the cell and requested one. Paramedics attended but were unable to resuscitate the man.

8. The man received good care at Brixton, but the investigation identified a number of learning points, including the need for efficient administrative arrangements for hospital appointments, revised emergency procedures and appropriate risk assessments for the use of restraints when escorting prisoners to hospital. We make four recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Brixton informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

10. The investigator obtained copies of the man's prison and medical records. She spoke to his cellmate at HMP Brixton on 7 November 2011 and interviewed seven members of staff at Brixton on 7 January 2014 and a further member of staff by telephone on 20 January. The investigator gave the Governor initial feedback about the investigation and followed this up in writing.

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

12. We informed HM Coroner for Inner South London District of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. Despite enquiries by the prison, Coroner and police, no members of the man's family could be traced.

14. The prison considered our draft report and its recommendations and has accepted them. No factual inaccuracies were raised. 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.

15. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, efforts to contact his family, his location, whether compassionate release was considered; and security arrangements for escort and bedwatch.

HMP BRIXTON

16. In July 2012, Brixton changed its function from a local prison to a category C prison with a particular emphasis on resettlement. The prison can hold almost 800 prisoners on five residential units. .

17. Healthcare provision is coordinated by Care UK and provided by a number of different contractors including the South London and Maudsley NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. A GP service runs from 8.00am until 5.00pm five days a week and nurses are available from 7.00am to 7.30pm every day.

HM Inspectorate of Prisons

18. The last inspection of HMP Brixton was in July 2013. The Inspectorate found that healthcare services were generally good and external appointments were well managed. However, inspectors noted that the proportion or older prisoners had increased significantly since the prison had changed its function and the needs of older prisoners were not always identified and met. There was no formal carer or buddy scheme for prisoners who needed additional support.

Independent Monitoring Board

19. 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 latest published annual report for the year to August 2013, the IMB commented that at the time the prison changed its function it was not ready for its new purpose. The IMB considered that healthcare services were good.

Previous deaths at HMP Brixton

20. Before the man's death there had been one other death from natural causes at Brixton since 2011. There were no significant similarities in the circumstances or the finding of the investigations.

ISSUES

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

21. The man was serving a four year sentence and had been at HMP Brixton since 2012. He had suffered from cancer in his mouth before he came to prison and reconstructive jaw surgery was planned. He was also being treated for chronic obstructive pulmonary disease (COPD) and cataracts.

22. An oncologist at the Royal Marsden Hospital saw him periodically as part of the follow up care for his mouth cancer. On 19 August 2013, the oncologist noticed a new lesion on his tongue which required further assessment.

23. On 9 September 2013, the man told the nurse that he had a pain in his waist area. The nurse arranged an appointment with the prison GP the next day. On 10 September, a doctor examined him and noted his abdomen was very tender. The doctor arranged for blood samples to be taken that day and prescribed pain relief.

24. On 11 September, another prison GP examined the blood test results and was concerned that they showed high CRP levels (C-reactive protein, raised levels of which indicate inflammation or infection). He saw the man urgently the next morning and told him that the planned jaw surgery might have to be put on hold until they knew more about what was currently making him ill. The GP took advice from a liver specialist at Kings College Hospital and made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

25. On 17 September, the lesion on the man's tongue was removed. Tests later showed that this was benign.

26. On 19 September, the man saw an oncologist at King's College Hospital who told him that his blood results indicated that he might have cancer. The oncologist arranged a CT scan for which the man attended hospital on 3 October.

27. On 7 October, the hospital telephoned the results of the CT scan to the GP. The scan showed widespread liver metastases (secondary cancer) and a pulmonary embolism in his right lung (a blockage of the main artery of the lung or one of its branches). At the time, it was not possible to identify the primary site of the man's cancer.

28. The same day, the GP spoke to the man, explained the results of the scan and sent him to hospital as an emergency to deal with the pulmonary embolism. The hospital discharged him later that day. The GP noted that further investigations were required but it was likely that any treatment offered, such as chemotherapy, would be palliative.

29. On 8 October, the doctor noted in the man's medical record that the prognosis was unclear as the hospital had not yet identified the site of the primary

cancer. She thought it possible that the man might be suitable for chemotherapy or radiotherapy, but this would depend on the primary site of the cancer.

30. On 17 October a surgeon at Kings College Hospital told the man that he had widespread liver cancer with the primary cancer possibly in the oesophagus (gullett). He noted that the man's abdominal pain and swelling was getting worse and that he was unable to swallow solid food. He was not fit enough for chemotherapy or radiotherapy. The surgeon told the man that the prognosis was not good and his life expectancy was weeks or months, and referred him for palliative care. He asked for an urgent endoscopy with a view to a biopsy to confirm the primary site of the cancer and to insert a stent if necessary.

31. Although the primary site of the cancer was never fully confirmed, we are satisfied that the man was appropriately diagnosed and informed of his condition.

The man's medical treatment

32. The man first reported being in pain on 9 September, before his diagnosis, and was given pain relief. This was regularly reviewed with advice from palliative care specialists when required. The clinical reviewer was satisfied that the man's pain was appropriately controlled.

33. On 18 October, the GP contacted the hospital. An oncology appointment was made for November and the hospital confirmed that the man was now not considered fit enough for jaw surgery. A multidisciplinary meeting was held at the prison that day to discuss the man's clinical needs.

34. The man was due attend hospital for an endoscopy and biopsy on 24 October to confirm the findings of the CT scan and that the primary site of the cancer was in the oesophagus. A stent would have been fitted if a significant blockage in his oesophagus had been found. Due to an administrative error at the prison about which prisoners were going to hospital that day, the man missed the appointment. A new appointment could not be re-arranged before his sudden death three days later. We do not know whether a stent would have been fitted at the appointment and the clinical reviewer does not consider it would have any significant effect on the outcome for the man. However, it is very concerning that this important appointment was missed. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that prisoners with serious conditions do not miss scheduled hospital appointments.

35. On 25 October, the man attended a multidisciplinary meeting with the deputy head of health care, the wing custodial manager, and a member of the safer custody team. The meeting discussed how best to meet his needs including pain management. The possibility of a move to a more suitable location and compassionate release were also discussed.

36. It does not appear that anyone discussed with the man whether he wanted resuscitation to be to be attempted in the event of a cardiac or respiratory arrest. The GP said that she felt that the man had received a lot of bad news and she wanted him to process this before considering the matter of resuscitation. The deputy head of healthcare also thought that they should wait for the results of further investigations which would enable a more accurate prognosis. As this was very shortly after his terminal diagnosis we agree that this was an appropriate approach.

37. On 27 October, at 3.10pm, an officer was in the man's cell and was talking to his cellmate when she noticed that the man had suddenly stopped breathing. She patted his arm but got no response. She noticed a little blood coming from his mouth and radioed an emergency code 1 to indicate a prisoner in a life threatening situation.

38. An officer was nearby and went immediately to the man's cell. He saw that the officer was administering chest compressions to try to resuscitate the man who was lying on the lower bunk. He described the man as very grey with blood coming out of his mouth. The officer was unable to find the man's pulse. He took over chest compressions until a nurse (the emergency response nurse) and another nurse arrived together at approximately 3.22pm.

39. An operational support grade (OSG) member of staff was in the control room. He said that control room staff did not automatically call an ambulance when an emergency code 1 was first received, but waited until the emergency response nurse or orderly officer asked them to call one. A nurse told the investigator that he asked the control room to call an ambulance at 3.23pm. The OSG requested an ambulance then.

40. The nurse could find no signs of life and moved the man and his mattress onto the floor. The nurse and the officers continued attempting resuscitation while the nurse went to get a defibrillator, which he returned with at 3.27pm. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) He attached the defibrillator to the man and it advised to continue resuscitation rather than shock.

41. Records show that the paramedic rapid response vehicle arrived at the prison at 3.34pm, an ambulance arrived at 3.35pm and a second ambulance arrived at 3.38pm. At 3.38pm, the first paramedics arrived at the cell and asked for resuscitation attempts to continue. Another paramedic arrived and took over resuscitation, but all attempts were unsuccessful. At 4.02pm, the paramedics pronounced the man's death.

42. The post-mortem report recorded the man's cause of death as aspiration of stomach content, liver metastases and carcinoma of the oesophagus

43. PSI 03/2013 was issued at the beginning of February 2013 and required governors to have a medical emergency response code protocol that instructs staff how to communicate the nature of a medical emergency using agreed

emergency codes and ensures that the control room calls an ambulance automatically, as soon as an emergency code is called. The instruction requires a two level code system that differentiates between a blood injury and all other injuries

44. HMP Brixton has a local policy which, although it applies to all medical emergencies, forms part of its Suicide and Self Harm policy. The policy has three codes, which does not comply with the PSI. The codes do not indicate to staff the type of incident they are going to encounter and what equipment to bring, so does not comply with the requirement that they should be sufficiently prescriptive to describe the incident which staff are responding to and trigger automatic contingencies. In this case for example, the code did not prompt healthcare staff to bring a defibrillator.

45. Code 1 is used at Brixton for life threatening situations. Although it requires the control room to call an ambulance straight away, neither the nurse nor the OSG were aware of this. It therefore took 28 minutes for paramedics to reach the man. Although it is unlikely to have changed the outcome for the man, such a delay could have serious consequences in another situation. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Brixton has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

The man's location

46. The man shared a cell on the second floor of G wing at Brixton. On 6 October, the man's cellmate told the nurse that the man was unable to use the stairs to get to the treatment room. From this point onwards, healthcare staff visited the man daily to give him his medication.

47. The man's cellmate told us that he found it difficult to manage in his cell. Apart from an extra mattress the man did not have any special equipment and did not have a designated carer or 'buddy' (a prisoner who helps others with daily living activities). This meant that the man's cellmate was usually required to act as an unofficial carer for him.

48. The wing custodial manager said she was aware that the man's location was far from ideal. She had arranged for him to move to a disabled cell on the ground floor, but he refused as he liked sharing a cell and said he was happy where he was. Consideration was being given to moving the man to a

hospice, but no firm arrangements had been made. We recognise that his death was very sudden and unexpected and consider that the prison made reasonable attempts to locate the man appropriately which took account of his preferences.

49. Brixton does not have a formal buddy or carer scheme. We were told that a policy was being developed, but had not yet been finalised. Although it appears that the man received good support from staff and other prisoners, and we commend the help he got from his cellmate, such help for infirm and terminally ill prisoners needs to be more structured. While other prisoners can help with routine tasks, there should be relevant checks and training before another prisoner acts as a carer or buddy. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care

Restraints, security and escorts

50. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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 which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

51. On 3 October 2013, the man went to King's College Hospital for a CT scan. A nurse completed the medical part of the risk assessment. He did not object to the use of restraints and recorded that the man's condition did not restrict his ability to escape unaided and that the restraints did not need to be removed for the scan. He did not consider that the man's mobility was impaired. A security collator, completed the security assessment and noted that the man did not have a history of escapes (or attempted escapes) from custody, absconds, hostage taking, violence or alcohol or drug abuse, but indicated that he was a risk to children. The security manager recommended single cuffs and an escort chain with two officers escorting. (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.) Restraints could be removed for life threatening emergencies, but if medical staff asked them to be removed for

other reasons the officers had to seek permission from prison managers first. A senior manager agreed the assessment.

52. On 16 October, the man had an appointment at the Royal Marsden Hospital. The nurse again completed the medical part of the risk assessment and gave the same information as before, but this time he noted that the man had difficulties walking, used a stick and could not walk long distances. Despite this, he wrote that the man's condition did not restrict his ability to escape unaided. The security risk assessment, completed and was the same as before except that it also noted he man had recently been unwell and his cellmate had been helping him. As before, the security manager recommended single cuffs and an escort chain with two officers escorting. The manager agreed.

53. On 17 October, the man had an appointment at King's College Hospital where he was told that he had widespread tumours and was not considered strong enough for chemotherapy or radiotherapy. The nurse again completed the medical assessment. The nurse noted the man had difficulties walking, but nothing further. The security risk assessment was the same as before. The security manager recommended single cuffs and two escorting officers and the senior manager, agreed this. However, a footnote on the risk assessment, by an Operations Manager, authorised just an escort chain on the grounds that the man was 'wheelchair bound'.

54. The investigator asked the nurse why he had not noted that the man was reliant on a wheelchair at the time. The nurse said that he had completed the risk assessments on 10 October, seven days before the appointment and the man's mobility must have deteriorated subsequently.

55. We were also told that medical assessments are not done in person, but from the computer records and daily feedback the team is given on individual cases. The team's administrator also sends a bundle of assessments to the team for all appointments scheduled for the following week. This means that medical risk assessments are always done in advance of the appointment, often by a number of days. In this case this means that they did not take sufficiently into account the man's rapid deterioration.

65. Security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are concerned that, despite the man's poor physical health and deteriorating mobility, he continued to be restrained and that the decision was not based on an up to date assessment. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

56. The man was not in contact with any family and did not nominate anyone as his next of kin. Although they had not had contact since his conviction, the man asked that the prison should inform his ex-partner in the event of his death.

57. When the man died, the Governor and another member of staff went to the address they had for the man's ex-partner but she had moved and left no forwarding details. The prison's family liaison officer contacted the police who also tried to find her, but was unsuccessful. In the absence of any family members, the family liaison officer organised a memorial service which prisoners attended on 18 November. He also organised and conducted the man's funeral on 2 December, the cost of which was covered by the prison.

Compassionate release

58. Prisoners can be released from custody on compassionate grounds for medical reasons before their sentence has expired. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

59. The manager told us she had been in contact with St Christopher's Hospice about a potential placement there. Although staff at King's College Hospital had indicated that the man's prognosis could be very short, further investigations were needed to ascertain the cancer's primary site and therefore to be clearer about how long he had left to live. Sadly, the man died very suddenly before this further information was obtained. We are satisfied that the prison had given appropriate consideration to the possibility of compassionate release.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure that prisoners with serious conditions do not miss scheduled hospital appointments.

2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Brixton has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

3. The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.

4. The Governor and the Head of Healthcare should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and the Head of Healthcare should ensure that prisoners with serious conditions do not miss scheduled hospital appointments.	Accepted	The prison and healthcare department will devise a strategy to protect appointments for those prisoners with serious medical conditions. This will include prioritising and using a system to alert the staff responsible for arranging the escort. The use of *Telemedicine* will also be explored to determine whether consultations can take place within the prison with appropriate professionals in hospital settings.	Healthcare Manager/ Head of Operations 31 May 2014	
2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Brixton has a Medical Emergency Response Code protocol which: • Provides guidance to staff on efficiently communicating the nature of a medical emergency; • Ensures staff called to the scene bring the relevant equipment; and	Accepted	The head of operations and healthcare manager will work together to implement a new Medical Emergency Response Code protocol. Staff will be briefed and trained on the protocol and its use will be embedded into the work of communications room.	Head of Operations/Healthcare Manager 31 May 2014	

	• Ensures there are no delays in calling, directing or discharging ambulances.				
3	The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.	Accepted	The healthcare manager will explore the feasibility of running a carers' scheme in order to select, train and supervise appropriate prisoner carers, ensuring they are equipped for personal social care.	Healthcare Manager 30 June 2014	
4	The Governor and the Head of Healthcare should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time	Accepted	Risk assessments for prisoners taken to hospital now take into account the individual's circumstances and the risk posed by the prisoner at the time. Healthcare will now provide an up to date medical assessment. Security are also more mindful of the medical conditions presented to them and will look at not using restraints if the medical evidence is such that it is unnecessary and not decent.	Healthcare Manager/Head of Security Completed and ongoing	