A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man in January 2014, while a prisoner at HMP High Down

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 January 2014, while a prisoner at HMP High Down. The man had been suffering from throat cancer. He was 64 years old. 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 HMP High Down.

The man arrived at HMP High Down on 14 June 2013. He had a history of coronary heart disease and had undergone a coronary artery bypass in 2011. In November 2013, he was diagnosed with throat cancer for which he had chemotherapy. On 2 January 2014, he had a feeding tube inserted to allow him to take in adequate nutrition. However, the man became increasingly unwell and, on 13 January, was admitted to The Royal Marsden Hospital where he died on 21 January. The cause of death was sepsis and peritonitis in reaction to the insertion of the feeding tube.

Although it did not affect the outcome, the investigation found that the initial diagnosis of throat cancer was a little delayed because the prison GP did not use a standard urgent referral form. After his diagnosis, I am satisfied that the man received an appropriate standard of care at the prison and was able to attend all his hospital appointments. The prison did not provide all the documents and risk assessments we requested, but from the available information I am concerned that the use of restraints was not always adequately justified when the man was taken to hospital appointments. It is also disappointing that the standard of family liaison appears to have been very poor, both before and after the man's death.

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 **September 2014**

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SUMMARY

1. On 4 June 2013, the man was sentenced to fourteen years imprisonment for sexual offences and transferred to HMP High Down on 14 June 2013. He had a history of heart disease and had undergone surgery for this in 2011. He continued to take medication and healthcare staff saw him frequently to monitor and manage his heart condition.

2. In August 2013, the man found a lump in his neck. A prison GP requested an immediate referral to a hospital specialist, but the administration team did not process this urgently, as the referral was not endorsed as urgent or as a 'two week referral'. When the man was in hospital on 11 September 2013 for other health matters, a hospital doctor examined the lump on the man's neck and made a further referral.

3. In November 2013, after tests, the man was told he had cancer of the throat. Plans were made for the man to have chemoradiotherapy (a combination of chemotherapy and radiotherapy). He had all his teeth removed as part of the preparation for this and a radiologically inserted gastrostomy (RIG) tube was put in place to allow the man to take in adequate nutrition during his treatment. (A RIG is when a narrow plastic tube is inserted through the skin, directly into the stomach under X-ray guidance).

4. A prison nurse saw the man on 12 January 2014 and noted that his face and neck were swollen. A GP saw him that afternoon and again the next day and prescribed antibiotic syrup.

5. During the afternoon of 13 January, a nurse became very concerned about the man's condition, she took advice from the hospital team responsible for his care and he was admitted to the Royal Marsden Hospital in Sutton, the same day.

6. The man remained in hospital, but his condition deteriorated and he died at 9.40pm on 21 January. His wife was with him at the time.

7. The cause of death was given as sepsis following the insertion of the RIG tube.

8. Although improvements are needed in the referral process for suspected cancer cases, the clinical reviewer found that the man's standard of care at the prison was generally good and we agree. However, we are concerned at the level of restraint used for the man's hospital appointments was not always justified by appropriate risk assessments and that family liaison arrangements were very poor. We make three recommendations.

THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. Two investigator interviewed three members of staff at HMP High Down on 14 of April and one member of staff on 22 April. 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 Surrey of the investigation, who provided the cause of death. We have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted the man's wife to explain the investigation. The man's wife was concerned about the prison family liaison. She said she had written to the Governor twice about the man's deteriorating health but did not receive a reply. After the mans' death she said she had left a number of messages for the prison family liaison officer, but did not receive a reply. The man's wife was also concerned that the prison had not returned a book which was of sentimental value to her.

14. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, his location, security arrangements for hospital escorts, liaison with his family and whether compassionate release was considered.

15. The man's family received a copy of the draft report. The solicitor representing the man's family wrote to us and raised a number of questions and we have provided clarification by way of separate correspondence to the solicitor. In response to their feedback, it is accepted that his disruptive behaviour in hospital could have been as a result of his medical condition. Further, they said the officers should have provided some privacy for the family when the man died. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP HIGH DOWN

16. HMP High Down is a local prison near Sutton, which holds around 1,100 men. NHS Surrey commissions healthcare services at the prison, which are provided by Virgin Care Services. There is a 22 bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP High Down was in July 2011. The Inspectorate found that the healthcare provision was very good, and supported by an impressive level and quality of staff. Prisoners were generally satisfied with their access to healthcare services. However, inspectors noted that there was a need to cater better for prisoners whose needs differed from the population as a whole because of their age, nationality or disability.

Independent Monitoring Board

18. Each prison in England and Wales 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 most recently published report for the year to November 2013, the Board concluded that healthcare in High Down had maintained its high standard of care, despite operating in a very difficult environment.

Previous deaths at HMP High Down

19. We have investigated four deaths from natural causes at High Down since 2013. We have raised the issue of the unjustified use of restraints in two other cases and another current investigation has identified the same issue. We have also previously drawn attention to the need to appoint a member of staff to liaise with families from the point a prisoner is diagnosed with a serious condition.

ISSUES

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

20. The man arrived at HMP High Down on 14 June 2013. At his initial health screen staff noted he had a history of coronary heart disease and he had undergone a coronary artery bypass in 2011. He continued to take medication for his heart disease. The man had been suffering from water retention for six months before he arrived at High Down and healthcare staff had frequent contact with him to monitor and manage his heart condition.

21. On 20 August 2013 a prison GP examined the man who was concerned about a lump on his neck. The GP found a hard two centimetre nodule on his neck and wrote a referral letter to Epsom General Hospital requesting an immediate review. The GP expected that the letter would be sent to the hospital without delay. However, administrative staff processed this as standard referral as it was not explicit that it was an urgent referral which requires patients with suspected cancer to be seen by a specialist within two weeks.

22. On 5 September, the nurse saw the man who was having breathing difficulties. She noted he had low oxygen saturation and a raised respiratory rate and he was taken to hospital by ambulance. He returned to the prison the same day with advice to take his diuretic medication which he needed because of fluid retention due to his heart condition.

23. The man was admitted to Epsom General Hospital from 9 to 11 September, because of facial swelling, low blood pressure and low oxygen saturation. A senior house officer, wrote to the prison on 11 September to say that he had discovered a lump on the man's neck and had referred him to the Ear, Nose and Throat (ENT) team at St George's Hospital in Tooting. The GP advised the prison doctor to follow this up.

24. In response to the GP's referral of 20 August, the man received a letter on 13 September, from St Helier Hospital, Carshalton, for a biopsy on his neck lump on 25 September. The man declined to attend this appointment and said that he felt fine.

25. On 7 October, the nurse chased the referral that the GP had made to St George's Hospital. The records do not show the outcome.

26. Between 11 and 17 October, the man was admitted to hospital with severe leg swelling, a complication of his heart condition. The discharge letter from the hospital noted that ENT doctors had examined the man because of a right sided neck lump. Prison GPs were asked to chase up the referral to the ENT department at St George's Hospital.

27. On 17 October, an ENT specialist at Epsom at St Helier Hospital Trust, telephoned High Down to ask why the man had not attended his appointment on 25 September. The nurse explained that the man had declined to attend.

28. Between 19 and 28 October, the man was in hospital with a pleural effusion (fluid around the lung). The discharge letter indicated that the pleural effusion had been drained and a scan had been carried out to investigate the man's neck lump. The letter also said that the hospital referred him to the ENT team at St George's Hospital again who would discuss his case on 1 November.

29. On 1 November, the GP examined the man as the lump on his neck was becoming increasingly painful and enlarged. He noted that the man had refused to attend an earlier appointment. The doctor arranged for the man to be taken to St George's Hospital that day, where he had a series of tests.

30. On 2 November, the hospital contacted healthcare staff at High Down to inform them that the lump was believed to be cancerous. The man was discharged from hospital the same day, with a further appointment for a biopsy and CT scan at St George's Hospital on 4 November.

31. The CT scan and biopsy revealed metastatic squamous cell cancer and a lesion in the man's throat. A Macmillan nurse and an ENT Consultant, the ENT consultant, saw the man on 4 and 7 November after an endoscopy and a further biopsy. They told the man about his diagnosis and gave him information about treatment options and support.

32. Although the clinical reviewer indicated that an earlier diagnosis would not have affected the outcome for the man, there was confusion about the referral procedure and poor communication between the two hospitals and healthcare staff at High Down. Epsom and St Helier Hospital Trust have standard referral proformas which clearly set out the reasons and urgency of referrals and using these would have prevented the confusion. Once a diagnosis was made, we are satisfied that the man was appropriately informed of his diagnosis and treatment options. We make the following recommendation:

    The Head of Healthcare should ensure that the priority and reasons for hospital referrals are clearly stated using standard proformas when appropriate and that urgent referrals are monitored and followed up as required.

The man's medical treatment

33. On 18 November, the man was admitted to St George's hospital to have his teeth extracted in preparation for his cancer treatment. He returned to the prison the next day. A specialist cancer nurse contacted healthcare staff at High Down that day to discuss his care. A puréed diet was ordered because the man was in some pain after his teeth had been removed.

34. On 21 November, the man attended St George's ENT department for a joint consultation with cancer specialists from the Royal Marsden Hospital. There were several subsequent appointments at the Royal Marsden leading to a plan for chemotherapy and thirty appointments for radiotherapy.

35. On 10 December, a consultant at the Royal Marsden Hospital discussed the treatment options with the man and went through the side effects and benefits of chemoradiation treatment which had been discussed with him at the earlier appointment. The man signed a consent form for the treatment. The hospital faxed the prison a full schedule of daily appointments starting on the 18 of December 2013 with a planned finish of 28 January 2014. The man attended all of these appointments until he died. It is apparent that High Down made good efforts to get the man to all his appointments on time.

36. The man's neck pain was controlled with paracetamol until 10 December, when the GP prescribed co-codamol. Another prison GP prescribed naproxen (an anti-inflammatory medication) on 11 December and omeprazole to protect the man's stomach from the side effects of the medication. On 18 December, a prison GP revised and increased the man's pain relief.

37. In anticipation that the man would have difficulty eating, the Royal Marsden team arranged for a radiologically inserted gastrostomy (RIG) to be fitted on 20 December. This was then postponed until 2 January 2014. The man was due to be discharged on 7 January but there was a delay due to complications inserting the RIG tube and he eventually went back to the prison on 9 January. A prison GP prescribed the medications detailed in the discharge plan and made arrangements for the medication to be crushed or provided in liquid form so it would be easier to take.

38. A nurse examined the man in the morning on 12 January, as she was concerned his face and neck were very swollen and puffy. The GP advised her to monitor him and he would assess him later that day. At 2.00pm, The GP examined the man and noted that, although he had refused to be fed through his tube, he had had something to eat and drink and his face was less swollen.

39. Another GP examined the man on 13 January and noted he was clinically dehydrated, his blood pressure was low and he had a rapid pulse. The doctor stopped the diuretics prescribed for his heart condition for two days, and prescribed amoxicillin antibiotic syrup to be given through his tube. That afternoon the nurse was concerned about the man's condition and rang the clinical team at the Royal Marsden hospital who advised that he should be admitted.

40. Healthcare staff contacted the hospital each day for an update on the man's condition. The man remained in the Royal Marsden Hospital, where his condition deteriorated. The nurse visited him at the hospital on 21 January and he died later that day at 9.40pm.

41. The cause of death was given as sepsis; peritonitis (caused by sepsis); following the recent insertion of the RIG tube due to right supraglottic squamous cell carcinoma (throat cancer).

42. We are satisfied that the man's received appropriate pain relief and his medical care was well managed at High Down.

The man's location

43. The man originally lived on a standard residential wing at High Down. However, due to his ongoing health problems, the man was admitted as an inpatient to the prison's healthcare unit on 6 September 2013. He remained there until he was admitted to the Royal Marsden Hospital on 13 January 2014.

44. We are satisfied that the man's location was appropriately managed and based on his health needs.

Restraints, security and escorts

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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.

46. The man went to hospital many times but the prison did not provide us with all the documentation we requested about the security arrangements. However, we reviewed five escort risk assessments for 5 September (when he was admitted to hospital with breathing difficulties), 9 September (again when he was admitted to hospital with breathing difficulties), 15 October (while the man was in hospital), 2 January (when the RIG tube was fitted) and 13 January (his final admission to hospital when he was very poorly).

47. The risk assessments record that cuffs were to be removed for treatment, but the escort logs do not always reflect that this was done. It was agreed that the man should not be restrained from 16 January 2014, although restraints were re-applied on 17 January for what was described as disruptive behaviour (which could have been a result of his medical condition). They were then removed again later the same day. The Governor reviewed the man's risk on 21 January 2014 and recorded that the escorting staff should wear civilian clothes and that the man should be restrained only if there was any

intelligence to suggest that he was at risk of escape. The man remained unrestrained from that point.

48. On each of these five assessments we reviewed, the risk assessments and escort logs indicate that the man was double cuffed. (Double cuffing is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) His risk was assessed as 'normal' for harm to public/hospital staff, hostage taking and escape. None of the medical sections of the risk assessment contained any information about whether the man's medical condition impacted on his risk of escape, as the 2007 High Court judgement requires. Medical input was confined to noting that there was no medical objection to restraints which is not the required test.

49. When interviewed, healthcare staff indicated that their understanding of their input to the risk assessment was a practical one relating to any injuries that might be affected by the use of restraints, rather than the impact of the prisoner's medical condition on their risk of escape. Staff told us they had received no advice on how to complete the assessment.

50. The investigator spoke to the head of security at High Down about the risk assessments and the use of double cuffs. The head of security acknowledged that specific training for all staff completing the risk assessments would be beneficial, but he believed that category B prisoners should be double cuffed by default. He did not refer to the implications of the court judgement or subsequent Prison Service guidance about escorting seriously and terminally ill prisoners to hospital.

51. We accept that double cuffing is the standard security requirement for moving category A or category B prisoners in good health, but when prisoners are seriously or terminally ill the decision about the level of restraint has to take into account their condition and be based on an individual risk assessment. Until the 16 January, the risk assessments for the man we examined appear to have been based entirely on the prison's view that all category B prisoners should be double cuffed when escorted. There is little evidence of any consideration of how the man's health condition impacted on this risk. We are therefore not satisfied that the man's physical health was appropriately taken into account in assessing his risk and the level of security needed for hospital escorts. We make the following recommendation:

    The Governor should ensure that all managers and staff responsible for undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

52. The man's wife told us that she had difficulty communicating with the prison after the man had been diagnosed with cancer. She told us she had written to

the Governor twice outlining some concerns about the man's care and difficulties with receiving visiting orders, but had only received one reply. We saw a letter from the Governor of 17 January in response to one of 1 January from the man's wife but there was no record of any other correspondence between the Governor and the man's wife, apart from a letter of condolence the Governor sent on 23 January. In his reply of 17 January, the Governor assured the man's wife that her concerns had been investigated and that the man's cancer care was in line with the treatment plan provided by the hospital. The Governor said that nurses had offered to help the man shave and change his clothes, but he had refused any assistance. A custodial manager said that staff had offered to help the man complete the required parts of the visiting order application, but he had refused.

53. The man's wife was present at the hospital when he died on 21 January. However, we are concerned that a family liaison officer from High Down did not contact her until 29 January. Our investigation revealed a considerable amount of confusion over the appointment of a prison family liaison officer.

54. Records show that a prison chaplain was informed of the man's death on the day he died, but she was not formally given the role of family liaison officer. There is confusion whether a prison family liaison officer was appointed immediately after the man's death. A custodial manager told us that he was informed at the morning meeting on 22 January, that the other manager was the family liaison officer. However, the manager was on a training course for two days. The custodial manager eventually spoke to the manager on 24 January. The manager said he was not aware he was the family liaison officer and he was not able to undertake the role at the time.

55. On 28 January, the custodial manager appointed an officer as the prison family liaison officer. The custodial manager telephoned the man's wife that day to apologise for the lack of earlier contact and told her that the family liaison officer would contact her.

56. The family liaison officer spoke to the man's wife on 29 January and on 3 February visited her at home to return the man's property. He informed her that the prison would contribute to funeral costs. The man's wife told us that she found it difficult to contact the family liaison officer after this visit and said she did not get a response to voicemail messages. The family liaison officer told the investigator that he was on annual leave shortly after being appointed and managers did not arrange any formal cover. He had told the man's wife that he had a pre-booked holiday and that she should contact the safer custody office in the prison if she needed anything while he was away.

57. The man's wife also told us she had not received all of his property, and a book of sentimental value was missing. The family liaison officer told the investigator that he had personally placed the book in the bag of property he had returned. Prison Service Instruction (PSI) 64/11 states that when returning property to a deceased prisoner's family a list of the items handed over should be kept and a receipt obtained from the family. The family liaison officer explained the man's wife declined to check the belongings when he

suggested this and would not sign for the property. The prison has not given us a list of property they returned to the man's wife so it is not possible to know whether the book was among the returned items.

58. PSI 64/2011 states that prisons must ensure arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill. Had this of been done, the man's wife would have had a point of contact when he was first diagnosed and we consider this would have helped avoid some of the communication difficulties she encountered. We consider that it was unacceptable that it was eight days after the man's death before a family liaison officer contacted his wife. We make the following recommendation:

The Governor should ensure that, an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a terminal or serious illness and that after their deaths a family liaison officer is appointed without delay and carries out the role in line with Prison Service guidance.

Compassionate release

59. Prisoners can be released from custody 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. The man was never given a prognosis. On 21 January, a nurse at the Royal Marsden Hospital discussed with the nurse the possibility of compassionate release, but the man died the same day before any action could be taken.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the priority and reasons for hospital referrals are clearly stated using standard proformas when appropriate and that urgent referrals are monitored and followed up as required.

2. The Governor should ensure that all managers and staff responsible for undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner presents at the time.

3. The Governor should ensure that, an appropriate member of staff is appointed to engage with families when a prisoner is diagnosed with a terminal or serious illness and that after their deaths a family liaison officer is appointed without delay and carries out the role in line with Prison Service guidance.

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 should ensure that the priority and reasons for hospital referrals are clearly stated using standard proformas when appropriate and that urgent referrals are monitored and followed up as required.	Accepted	Specific templates have been added to System One for use when prisoners require urgent referrals. The letterheads for these referrals are clearly marked and the administration team are aware of how to process them correctly.	Complete Head of Healthcare	
2	The Governor should ensure that all managers and staff responsible for undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Local Security Strategy at HMP High Down has been revised to ensure that appropriate risk assessments take place when prisoners are taken to hospital, and medical opinion will now always be considered when determining an individual's actual risk at the time of assessment. The Head of Security has briefed all staff undertaking risk assessments about the legal position and the revised Local Security Strategy, and further notices will be issued to staff in the future to remind them of their responsibilities when completing assessments.	Complete Head of Security	
3	The Governor should ensure that, an appropriate member of staff is appointed to engage with families	Accepted	Contingency plans outline when Family Liaison Officers (FLO) should be appointed. The Head of Healthcare will advise the Safer	July 2014 Head of	

	when a prisoner is diagnosed with a terminal or serious illness and that after their deaths a family liaison officer is appointed without delay and carries out the role in line with Prison Service guidance.		Custody department when prisoners are diagnosed with terminal or serious illnesses so that FLOs can be appointed at the earliest opportunity. The FLOs at High Down will be briefed about their roles and duties to ensure compliance with PSI 64/2011.	Healthcare	