



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death in October 2014
of a man at HMP Hull**

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 of lung cancer on 1 October 2014 at HMP Hull. He was 76 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Hull. The prison cooperated fully with the investigation.

The man was sentenced to nine years in prison in 2010 and transferred to HMP Hull in 2012. He complained of a persistent cough from September 2013, but no one referred him for a chest X-ray as national guidance advises. In May 2014, a doctor diagnosed the man with a urinary tract infection and ordered blood tests, which were done five days later. The results were concerning and the man was admitted to hospital for further urgent tests. In hospital, doctors diagnosed lung cancer. He began a course of chemotherapy, but discontinued this in September as he was too weak. The man was nursed in the prison's palliative care suite, where he died on 1 October.

We do not know whether an earlier referral for tests, because of the man's ongoing cough, would have led to an earlier diagnosis, but the clinical reviewer considered that this was a missed opportunity. After his diagnosis I am satisfied that the man received very good care at the prison, equivalent to that he would have expected to receive in the community. However, I am concerned that, on occasions, prison staff used restraints when the man went to hospital without appropriate risk assessments to justify their use.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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1. Clinical review

SUMMARY

1. On 22 December 2010, a man was sentenced to nine years in prison. He had a history of angina, arthritis and a stomach ulcer. He transferred to HMP Hull on 4 December 2012.
2. On 16 September 2013, a nurse referred The man to a GP as he had a cough and the GP prescribed antibiotics. The man reported having a cough three more times that year. It is not clear whether the antibiotics helped. In February 2014, he told a GP his chest was tight and considered his angina was worsening. In April, he reported stomach pains and a GP diagnosed indigestion.
3. On 5 May, The man told a GP he had blood in his urine. He gave a urine sample but further samples were needed. On 9 May, the doctor asked for urgent blood and urine tests, but did not indicate the urgency on the electronic medical record and nurses did not take these until 14 May. The results, received that day, showed low electrolyte levels and The man was admitted to hospital for tests and treatment. Investigations revealed that he had a stomach ulcer and lung cancer, which appeared to have spread to his liver. On 28 June, the hospital discharged him back to the prison.
4. Healthcare staff at the prison initiated care plans to ensure The man was nursed appropriately and was kept comfortable. Initially he had chemotherapy at hospital, but became too unwell to cope with it. Prison staff restrained The man each time he went to hospital for treatment.
5. In June, the prison considered making an application for compassionate release, but did not progress the application as The man had no clear prognosis. In September, they decided to pursue an application, but this had not been completed by the time that The man died.
6. We agree with the clinical reviewer that, overall, The man received a good standard of care after doctors diagnosed his cancer. However, we consider he should have been referred to a specialist earlier, because of his ongoing cough. There was also a hold up with urgent blood and urine tests. We consider that the use of restraints for hospital appointments and stays was not always justified by fully considered risk assessments. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

7. The investigator, Ms Claire Parkin, issued notices to staff and prisoners at HMP Hull informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. Ms Parkin obtained copies of The man's prison medical records and relevant extracts from his prison records. She informed the Governor of the preliminary findings of the investigation.
9. NHS England commissioned Mr Terry Dutchburn to review The man's clinical care at the prison.
10. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers, Ms Laura Spargo, contacted The man's next of kin, his grandson, on 3 November, to explain the investigation. He did not have any specific issues for the investigation to consider. He also received a copy of the draft report and did not make any comments.
12. The prison also considered our draft report and did not raise any inaccuracies. They submitted an action plan addressing our recommendations which is at the end of this report.
13. The investigation has assessed the main issues involved in The man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

HMP HULL

14. HMP Hull is a local prison, which holds up to 762 men in ten wings. City Healthcare Partnership provides health services at the prison. There is an inpatient unit with 24-hour nursing cover, which holds a mixture of prisoners with mental health conditions and physical health problems. GP surgeries are held four days a week, with an out of hours service available at other times. The inpatient unit includes a specialist palliative care suite.

HM Inspectorate of Prisons

15. The report of the most recent inspection of HMP Hull in October 2014 has yet to be published. At the previous inspection in February 2012, the Inspectorate found that healthcare had improved and there was a specific member of staff to lead on the care of older prisoners and those with disabilities.

Independent Monitoring Board

16. 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. There are no recent annual reports from the IMB at Hull.

Previous deaths at HMP Hull

17. The man's death was the fourth from natural causes at Hull in the last two years. We have made recommendations about the need for appropriate risk assessments for the use of restraints before.

ISSUES

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

18. The man was serving a nine year prison sentence and had been at HMP Hull since December 2012. He had a history of angina, arthritis and a stomach ulcer which doctors managed with appropriate medication.
19. On 16 September 2013, The man told Nurse Christopher Horner that he had a cough, producing white phlegm. Nurse Horner recorded that The man's chest was clear but referred him to see a GP. The next day, Dr Simone Muehlbayer examined The man and prescribed antibiotics to be reviewed on 28 October.
20. On 28 October, The man told Dr Ian Grantham that, initially, his cough had cleared with the antibiotics but had now returned. He was producing white phlegm again. The doctor prescribed further antibiotics.
21. On 7 November, The man was still coughing and bringing up phlegm. Nurse Suzanne Kinch, a nurse prescriber, prescribed further antibiotics and arranged for him to see a GP the next week. On 14 November, Dr Sanjay Duhan prescribed medication to help break down phlegm, as The man said he had chest pain and a productive cough. The man had no further interaction with healthcare staff until February 2014.
22. On 6 February 2014, The man told Dr Duhan that his chest was tight and he thought his angina might be getting worse. The doctor and The man agreed that if the tightness continued or got worse, Dr Duhan would increase his medication for angina. There is nothing further in The man's medical record until 4 April, when The man told a prison GP, Dr Abayomi Ogunba, that he thought his stomach ulcer might have returned. The doctor diagnosed indigestion and prescribed lansoprazole to decrease stomach acid.
23. On 5 May, The man told Dr Ogunba that he had blood in his urine. The doctor took a urine sample but, on 7 May, the pathology team asked for another sample. On 9 May, Dr Ogunba saw The man and prescribed antibiotics for a urinary tract infection. He noted that The man should have urgent urine and blood tests, but sent this as a routine task on SystmOne, the electronic healthcare record, rather than as an urgent task.
24. On 14 May, nurses took urine and blood samples. The hospital analysed the samples that day and informed the prison that The man had low sodium and chloride levels which needed urgent treatment. He was admitted to Hull Royal Infirmary that night and stayed in hospital for approximately six weeks for tests and treatment. A scan showed a stomach ulcer and masses on his lungs and liver.
25. On 29 May, after further tests, hospital staff told The man that he had incurable lung cancer, which had spread, although chemotherapy to provide a

degree of remission was a possibility. The hospital informed the prison and Nurse Kinch visited him the next day to offer support.

26. The National Institute for Health and Care Excellence (NICE) quality standard for lung cancer (2011) says that, if anyone has a persistent cough for more than three weeks, clinicians should refer them for a chest X-ray. The man had been repeatedly complaining of a productive cough since September 2013, but he did not have an X-ray. A hospital consultant did not see The man until May 2014, after abnormal blood tests. Dr Duhan, who saw The man in 2013 and 2014, acknowledged that a chest X-ray might have been appropriate, although he did not feel that The man had any other symptoms suggestive of cancer at the time. We consider doctors should have referred The man for a chest X-ray earlier.
27. Dr Ogunba requested repeat blood and urine tests on 9 May, but he did not mark the request as an urgent task on SystmOne which meant that nurses did not take samples until 14 May. Although this relatively short delay is unlikely to have affected the outcome, it is important that the need for urgent tests is clearly identified. We make the following recommendations:

The Head of Healthcare should ensure clinicians follow NICE guidelines for lung cancer and refer prisoners for X-rays in line with the guidance.

The Head of Healthcare should ensure all clinicians understand and follow the SystmOne procedures for making urgent requests for tests.

The man's medical treatment

28. After his diagnosis, healthcare staff at the prison planned The man's care well before he was discharged from hospital on 28 June and began to prepare the prison's palliative care suite for him. They ordered a special mattress and made a referral to Macmillan nurses.
29. The man had chemotherapy in hospital. When he came back to the prison on 28 June, further chemotherapy was planned. Healthcare staff drew up care plans to ensure he received appropriate medication, food, fluid and pressure area care. They reviewed the plans frequently.
30. Hospital doctors had decided that The man should not be resuscitated if he had a cardiac or respiratory arrest. They had not discussed this with The man who was becoming increasingly confused and disoriented and they had concerns about his mental capacity. On 1 July, the prison arranged an independent mental capacity assessment, which concluded that The man did not have full capacity to make a decision about his treatment. However, the independent assessor was satisfied that his treatment plans were appropriate.
31. Because The man had very low blood sodium levels the hospital delayed his second round of chemotherapy. He was admitted to hospital from 23 July to 28 July to stabilise his blood sodium levels and he continued his

chemotherapy on 7 August in hospital. The hospital admitted him again from 27 August to 5 September to stabilise his blood again.

32. The man deteriorated significantly and, on 17 September, his oncologist told Nurse Vicky Jackson that he was not fit enough to withstand any more chemotherapy at the time. The hospital therefore discontinued his treatment.
33. Clinical staff at the prison managed The man's pain by increasing his medication as his condition deteriorated. They liaised with a Macmillan palliative care pharmacist and took advice on pain relief, using butrans patches (opioid pain relief), morphine injections and oramorph (liquid morphine). The man suffered some mental agitation and doctors prescribed haloperidol injections (antipsychotic medication) to manage this.
34. In the last fortnight of his life, The man was unable to move on his own, he had difficulty swallowing and he was often disorientated. Healthcare staff reviewed him daily and updated his care plans to ensure he was as comfortable as possible. He died on 1 October. Nurse Ingrid Boulton was with him at the time.
35. We agree with the clinical reviewer that after his diagnosis, The man's clinical care was of a high standard.

The man's location

36. When The man left hospital on 28 June, he moved to the palliative care suite at the prison, which the staff had prepared for him. This is an adapted double sized cell with en-suite facilities and had a specialist bed and chair. The suite allows easy access for nursing and has appropriate accommodation for seriously ill prisoners. We agree with the clinical reviewer that the location was suitable to meet The man's needs.

Restraints, security and escorts

37. 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 a prisoner's risk of escape (and the risk to the public in the event of an escape) when fit and the risk when the same prisoner is 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 and kept under review as circumstances change. It found that restraining a prisoner by handcuffs who was 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.

38. When The man was admitted to hospital urgently on 14 May, prison staff did not assess his risk and healthcare staff did not comment on his condition. Two officers escorted him and used handcuffs to restrain him. The next day, a senior manager agreed that the handcuffs should be replaced by an escort chain. (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.) On 10 June, after nearly a month in hospital, during which The man was diagnosed with advanced cancer and had chemotherapy treatment, a prison manager, Mr Christopher McPhee, decided that restraints were no longer necessary. He noted that The man's condition had deteriorated and he no longer presented the same risk. He remained unrestrained in hospital until he went back to the prison on 28 June.
39. The prison was unable to find the records for The man's admission to hospital in July or for his chemotherapy appointment on 7 August, so we do not know whether they used restraints during that time. There was no risk assessment for The man's hospital admission on 27 August and officers used an escort chain to restrain him. On 28 August, Mr McPhee agreed that restraints should not be used again.
40. The prison said that when The man went to hospital on 14 May it was an emergency and it was not possible to carry out a risk assessment in advance. However, the hospital called the prison at 9.25pm, and we consider there was sufficient time for a risk assessment before The man left for hospital at 11.55pm. On 27 August, the prison again said there was insufficient time for a risk assessment, but the records show that a manager briefed the escort officer at 8.00am and The man was not admitted to hospital until 1.20pm. In any event, at that time, the prison was aware of The man's condition and a manager had decided in June that restraints did not need to be used. It is unsatisfactory that there are no records available for The man's hospital admission in July or for his subsequent chemotherapy treatment in August.
41. We are not satisfied that appropriate risk assessments were always carried out and kept under review. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time and are kept under review.

Liaison with The man's family

42. The man did not want to contact his family when he became ill and he would not give prison staff any contact details for a next of kin. Staff checked this with him periodically, but he continued to refuse to give any details.

43. Although there is no record of when this happened, we were told that The man changed his mind and Mr McPhee contacted his grandson on his behalf, some weeks before his death. The man's grandson did not want to visit, but asked Mr McPhee to telephone him when his grandfather died. Mr McPhee telephoned his grandson on the day The man died but got no reply. He informed him of his grandfather's death the next day. Mr McPhee attended The man's funeral on 9 October. The prison paid for the funeral, in line with national guidance.

Compassionate release

44. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).
45. The prison considered The man's suitability for compassionate release twice. On 2 June 2014, the acting Governor, Ms Allison Watson, in consultation with relevant staff involved in The man's care concluded that, as The man, had not received a prognosis, they would not make an application for release at the time.
46. On 26 September, although there was still no definite prognosis, Ms Watson considered that it was now appropriate to make an application for early release. On 29 September, Mr Darran Cook, a Senior Probation Officer, completed his section and forwarded the application for a doctor to complete the medical report. Unfortunately, The man died before the application was progressed. While an earlier review of The man's suitability for compassionate release would have been preferable, in the circumstances of The man's case, it seems unlikely that he would have met the criteria.

RECOMMENDATIONS

1. The Head of Healthcare should ensure clinicians follow NICE guidelines for lung cancer and refer prisoners for X-rays in line with the guidance.
2. The Head of Healthcare should ensure all clinicians understand and follow the SystemOne procedures for making urgent request for tests.
3. The Governor and Head of Healthcare should ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time and are kept under review.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure clinicians follow NICE guidelines for lung cancer and refer prisoners for X-rays in line with the guidance.	Accepted	<p>A full review has been conducted and a clear patient pathway has been implemented. GPs and clinicians are now following the NICE guidelines.</p> <p>CHCP-Governance team cascade all NICE updates, these are reviewed and discussed with the team at a weekly clinical team meeting in future all NICE will be discussed at the GP team meetings</p>	<p>Head of Healthcare</p> <p>Completed</p>
2	The Head of Healthcare should ensure all clinicians understand and follow the Systm1 procedures for making urgent request for tests.	Accepted	<p>Discussed at the clinical team meetings and process clarified so all clinicians use the 'task' system on SystmOne.</p> <p>Lessons learned from this review have been implemented and cascaded to all clinicians who now understand the process for urgent requests for tests when required.</p>	<p>Head of Healthcare</p> <p>Completed</p>
3	The Governor and Head of Healthcare should ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents	Accepted	All Governors and staff undertaking risk assessments for prisoners taken to hospital have been fully briefed to ensure they fully understand the legal position and the assessments take into account the health of a prisoner and must be based on the actual risk the prisoner presents at	<p>Head of Healthcare</p> <p>Head of Security</p> <p>Completed</p>

	at the time and are kept under review.		the time and to ensure that they are kept under review.	
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