Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Kershaw a prisoner at HMP Buckley Hall on 17 August 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Kershaw died of a heart infection and lymphoma while a prisoner at HMP Buckley Hall on 17 August 2015. He was 47 years old. I offer my condolences to Mr Kershaw's family and friends.

I consider that Mr Kershaw received a good standard of care from the time he first reported symptoms in July 2015. Sadly, Mr Kershaw died very soon after he became ill. Although suspected, the lymphoma was not confirmed until after his death. I am satisfied that Mr Kershaw received appropriate nursing and medical care and was referred to specialists quickly, in line with National Institute for Health and Care Excellence (NICE) guidelines.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. In 2008, Mr David Kershaw received a life sentence for murder. Mr Kershaw had a history of intravenous drug use, depression, hepatitis C and high blood pressure.

2. During July 2015, while he was at HMP Haverigg, Mr Kershaw suffered intermittently with a cough, was short of breath and lost weight. He reported having pains in his arms and legs. On 24 July, a GP diagnosed phlebitis (inflamed veins.) On 29 July he transferred to Buckley Hall. The day after he arrived, a doctor reviewed him and referred him for an urgent X-ray which showed a mass on his chest. A subsequent CT scan, on 7 August and further tests revealed that Mr Kershaw had multiple blood clots in his legs, brain, lungs, and a hole in his heart. Doctors suspected that he might have lymphoma and he was admitted to hospital for further tests.

3. On 10 August, while he was in hospital, Mr Kershaw had a stroke and on 12 August, he was transferred to a specialist coronary care unit. Doctors diagnosed endocarditis (a rare infection of the inner lining of the heart). Mr Kershaw's condition declined and he died in hospital on 17 August.

Findings

4. We are satisfied that Mr Kershaw received a good standard of healthcare and had timely referral to specialists in line with national guidance. The clinical reviewer noted that further investigation at the time Mr Kershaw was diagnosed with phlebitis might have identified blood clots a little earlier, but concluded that there did not appear to have been any missed opportunities for earlier intervention, particularly in light of the conclusions of the post-mortem report. We consider there was a proportionate approach to security, which meant that Mr Kershaw was not restrained for the last week of his life. We make no recommendations.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Buckley Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

6. The investigator obtained copies of relevant extracts from Mr Kershaw's prison and medical records.

7. NHS England commissioned a clinical reviewer to review Mr Kershaw's clinical care at the prison.

8. We informed HM Coroner for the Manchester North district of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted Mr Kershaw's mother, to explain the investigation. His mother had no specific matters for the investigation to consider.

10. Mr Kershaw's family received a copy of the initial report. They did not make any comments.

11. The prison also considered our initial report and did not raise any factual inaccuracies.

Background Information

HMP Buckley Hall

12. HMP Buckley Hall is a medium secure prison holding just over 400 men. There are four residential blocks, one of which is a dedicated drug recovery wing.

13. Manchester Mental Health and Social Care Trust provide healthcare seven days a week. A multidisciplinary team of GPs, general and mental health nurses provide health services, including clinics for long term conditions, between 7.45am and 7.45pm on weekdays.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Buckley Hall was in April 2012. Inspectors reported that the prison needed to focus on the promotion of equality, environmental standards and issues with the availability of drugs. At the time, Pennine Care NHS Foundation trust provided healthcare and prisoners were generally satisfied with the access to and quality of care received.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2015, the IMB reported that staffing levels were a concern but the prison was performing satisfactorily. The Board considered healthcare staff competent, conscientious and caring and that healthcare services were sound.

Previous deaths at HMP Buckley Hall

16. Mr Kershaw was the first prisoner to die from natural causes at Buckley Hall since 2009. There were no similarities with the circumstances of the previous death.

Key Events

17. Mr David Kershaw received a mandatory life sentence for murder in September 2008. He spent time at a number of prisons during his sentence. He had a history of intravenous drug use (although records show he had not used drugs for approximately five years), hepatitis C, depression and, briefly, high blood pressure.

18. At HMP Haverigg on 15 July 2015, a nurse recorded that Mr Kershaw was struggling to breathe and thought he had a chest infection. He told her that he had intentionally lost 6.5kg (just over a stone), over the previous year. He weighed 69.7kg (10st 13lbs). She examined him and noted that his clinical observations were normal. She planned to review him again and to discuss his symptoms with a GP, if they persisted. On 20 July, she noted Mr Kershaw was coughing intermittently. His ankles were swollen and he said he felt as if he had a large lump in his chest. He now weighed 66.8kg (10st 5lbs). She had already made an appointment for him to see a doctor on 24 July.

19. On 24 July, Mr Kershaw told a prison GP that he had pains in his arms and legs. He had been coughing for three weeks and had been short of breath for four weeks. The doctor found his chest was clear and considered he had a viral infection and superficial phlebitis (inflammation of the veins just under the skin in the arms and legs). She noted that he had lost a stone in the previous three weeks and ordered full blood tests. However, on 27 July, Mr Kershaw would not let healthcare staff take any blood because he was in discomfort with the pain in his arms. Later the same day, a locum GP saw Mr Kershaw and prescribed an antibiotic, pain relief and heparinoid (a gel used to treat inflammation and bruising of the skin and blood vessels).

20. On 29 July, Mr Kershaw transferred to Buckley Hall, as a planned move. At an initial health screen, a nurse noted that he was not able to work at the time because of health problems and that he was on medication for phlebitis. A prison GP examined Mr Kershaw the next day and recorded that he had phlebitis and a dry cough, but his chest was clear. The GP noted Mr Kershaw had been losing weight. The doctor prescribed penicillin, anti-inflammatory medication and paracetamol and referred Mr Kershaw for an urgent chest X-ray and blood tests.

21. On 30 July, a chest X-ray showed that Mr Kershaw had a potential mediastinal mass (a mass in the area of the chest that separates the lungs). The radiologist recommended that Mr Kershaw should be referred for a CT scan to provide more detail.

22. On 4 August, Mr Kershaw told a nurse that he had pain and discolouration in his arms and legs. He advised Mr Kershaw to continue with his phlebitis medication and arranged for a GP to see him. The GP reviewed him later that morning and prescribed ibuprofen, paracetamol and an antibiotic. The nurse took blood tests and the results suggested he had an infection.

23. On 7 August, a nurse and a GP saw Mr Kershaw before his CT scan scheduled for that day. Mr Kershaw told the GP that he felt unwell, had been coughing up blood and bile that morning and had pain and dizziness when he walked for a few minutes. The GP discussed Mr Kershaw's symptoms with hospital staff and

told Mr Kershaw that there was a possibility the CT scan might show a malignancy (cancer). Mr Kershaw was taken to hospital by taxi for the scan. He was handcuffed and escorted by two officers.

24. The CT scan showed that Mr Kershaw had blood clots in his abdomen and legs. Hospital doctors considered that Mr Kershaw might have lymphoma (cancer of the blood) but asked for further investigations. Mr Kershaw moved to another hospital for more tests. A prison manager reviewed the security arrangements and decided that Mr Kershaw should be restrained by an escort chain (a long chain with a light handcuff at each end, one attached to the prisoner the other to an officer).

25. On 8 August, the prison appointed a prison family liaison officer (FLO). The FLO telephoned Mr Kershaw's mother and informed her that her son was in hospital. The Head of Healthcare also spoke to Mr Kershaw's mother about Mr Kershaw's potential diagnosis. The prison arranged transport for Mr Kershaw's mother to visit him in hospital.

26. Prison healthcare staff kept in contact with the hospital each day for updates on his condition. At 3.00am on 10 August, Mr Kershaw suffered a stroke and the escorting officers removed the escort chain. Later that day, hospital staff said he had a chest mass and blood clots in his legs, lungs and brain. He also had a hole in his heart. Doctors still suspected lymphoma, but this had not yet been formally diagnosed.

27. On 12 August, Mr Kershaw's condition deteriorated further and he transferred to another hospital's coronary care unit for a detailed scan of the inside of his heart. Two consultants considered that further treatment at the time was not appropriate and Mr Kershaw was taken back to the treating hospital. On 13 August, a member of healthcare staff at the prison noted that the hospital had told her that Mr Kershaw had been diagnosed with endocarditis (a rare infection of the inner lining of the heart). The hospital planned to treat Mr Kershaw with intravenous antibiotics for six weeks. Mr Kershaw's condition deteriorated over the next days and he died in hospital on 17 August.

28. A prison manager and an officer visited Mr Kershaw's mother to inform her that he had died and offered condolences and support. In line with national policy, the prison contributed to the cost of Mr Kershaw's funeral, which was held on 14 September.

Support for prisoners and staff

29. After Mr Kershaw's death, a prison manager debriefed the escorting officers and offered them his support and that of the staff care team.

30. The prison posted notices informing staff and prisoners of Mr Kershaw's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Kershaw's death.

Post-mortem report

31. The post-mortem report recorded the cause of death as 1a) Myocarditis (inflammation of the heart muscle) 1b) Infective Endocarditis and 2) High grade anaplastic peripheral T cell lymphoma (cancer of the blood).

Findings

Clinical care

32. Mr Kershaw complained of pains in his arms and legs, shortness of breath, a cough and discomfort in his chest while still at Haverigg in July 2015. A nurse quickly referred him to a GP, who examined him on 24 July and considered he had a viral infection and phlebitis. The GP noted his weight loss and asked for blood tests. Unfortunately Mr Kershaw refused the blood tests because of pain in his arms.

33. On 29 July, Mr Kershaw moved to Buckley Hall and a doctor reviewed him the next day. The doctor was concerned about his weight loss and persistent cough and appropriately referred Mr Kershaw for an urgent X-ray. The X-ray was abnormal and a subsequent CT scan and further tests on 7 August revealed Mr Kershaw had a number of blood clots and a hole in his heart. Hospital doctors suspected that he might also have lymphoma.

34. In relation to the post-mortem results, which found venous thromboembolisms (blood clots in the vein), the clinical reviewer noted that at the time Mr Kershaw was diagnosed with phlebitis, there was a possible missed opportunity to investigate the cause further. However, Mr Kershaw was referred for specialist tests very shortly afterwards. The clinical reviewer concluded that prison healthcare staff appropriately investigated Mr Kershaw's symptoms and referred him for further investigations in line with NICE guidelines.

35. The clinical reviewer considered that the overall standard of healthcare Mr Kershaw received was equivalent to that he could have expected to receive in the community. Mr Kershaw died very quickly after first reporting symptoms of ill-health. We are satisfied that he received appropriate care at the prison and there was no delay referring him to specialist care.

Restraints, security and escorts

36. When prisoners travel outside prison, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. The level of restraints used should be necessary in the circumstances and based on a risk assessment, which considers the risk of escape and the risk to the public. It should takes into account factors such as the prisoner's health and mobility.

37. On 7 August, Mr Kershaw went to hospital for a planned CT scan. At the time he was fully mobile and his risk to the public and of escape was assessed as medium. Mr Kershaw was handcuffed for the appointment. After he was admitted to hospital, a manager reviewed the risk assessment and decided that an escort chain should be used. Officers removed the chain in the early hours of 10 August, when Mr Kershaw suffered a stroke. Restraints were not used after that. We are satisfied that there was a proportionate approach to the use of restraints and the risk was reviewed as Mr Kershaw's condition changed.

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