Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Brook a prisoner at HMP Hull on 29 February 2016

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 Graham Brook died from bronchopneumonia caused by bowel cancer, at HMP Hull, on 29 February 2016. He was 65 years old. I offer my condolences to Mr Brook's family and friends.

I consider that the standard of healthcare Mr Brook received at Hull was at least equivalent to that he could have expected to receive in the community. Throughout his illness, healthcare staff considered Mr Brook's physical and emotional needs and treated him with care and compassion.

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 **September 2016**

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Summary

Events

1. On 16 October 2010, Mr Graham Brook was remanded to HMP Hull. He was later sentenced to ten years in prison. In January 2012, Mr Brook decided he did not want to take part in NHS bowel cancer screening programme.

2. On 6 June 2014, Mr Brook reported severe abdominal pain. A prison GP diagnosed indigestion, gave Mr Brook dietary and lifestyle advice. He requested a stool sample test, which showed an abnormal iron level. The doctor referred Mr Brook urgently to a consultant gastroenterologist for suspected cancer. Tests were normal, but in December Mr Brook refused to go to hospital for a colonoscopy which the consultant had arranged to investigate further. After he reported further symptoms in January 2015, the prison GP made another urgent referral, but hospital tests in February revealed no abnormalities. On 25 June, Mr Brook again declined routine screening for bowel cancer.

3. On 30 October, Mr Brook reported longstanding pain in his left thigh. Blood tests showed he had anaemia, and the GP referred him to a vascular surgeon. He was admitted for further tests and doctors diagnosed terminal bowel cancer which had spread to his lungs.

4. On 10 November, the hospital discharged Mr Brook and he was admitted to the prison's wellbeing unit. Healthcare staff produced a palliative care plan, in consultation with hospital doctors and a community palliative specialist. They assessed his pain every day and gave appropriate medication and support. On 16 December, Mr Brook moved to the prison's palliative care suite, as his condition had deteriorated and he needed increased support and pain relief.

5. At 6.15pm on 29 February, Mr Brook's breathing became shallow and then stopped. Cardiopulmonary resuscitation was unsuccessful and at 6.29pm, a doctor recorded that Mr Brook had died.

Findings

6. The clinical reviewer noted that if Mr Brook had agreed to bowel cancer screening and a colonoscopy in December 2014, doctors might have diagnosed the cancer sooner and offered active treatment. It is not possible to know if this would have changed the outcome.

7. We consider that Mr Brook received a good standard of care at Hull, equivalent to that he could have expected to receive in the community. Prison healthcare staff worked effectively with hospital and community palliative staff to manage Mr Brook's condition, with care and sensitivity.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

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

12. One of the Ombudsman's family liaison officers contacted Mr Brook's wife to explain the investigation. Mr Brook's wife did not have any specific matters for the investigation to consider and said that prison and healthcare staff had treated him very well and she could not fault them.

13. The investigation has assessed the main issues involved in Mr Brook'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.

14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

15. Mr Brook's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

Background Information

HMP Hull

16. HMP Hull is a local prison, which holds over 1000 men in ten wings. City Healthcare Partnership provides health services at the prison. There is an wellbeing unit with 24-hour nursing cover, which holds a mixture of prisoners with mental health conditions and physical health problems. The wellbeing unit includes a palliative care suite. GP surgeries are held four days a week, with an out of hours service available at other times.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Hull was in October 2014. Inspectors reported that health services were generally good, and most prisoners were reasonably satisfied with the quality and access to healthcare services. The prison offered a wide range of primary care clinics and healthcare screening programmes, and prisoners could usually see a GP within three days. Palliative care arrangements were effective.

Independent Monitoring Board

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

Previous deaths at HMP Hull

19. There have been seven deaths from natural causes, at HMP Hull, since the beginning of January 2014. There were no significant similarities between the circumstances of Mr Brook's death and those we have already investigated.

Findings

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

20. On 16 October 2010, Mr Graham Brook was remanded to HMP Hull, charged with sexual offences. On 18 May 2011, he was sentenced to ten years in prison.

21. On 30 January 2012, Mr Brook was invited to take part in the NHS bowel cancer screening programme. This is offered every two years to people aged 60 to 74 and aims to detect bowel cancer early, when successful treatment is more likely. Mr Brook declined screening.

22. In June 2014, Mr Brook reported severe abdominal pain after eating. A prison GP diagnosed indigestion, gave him dietary and lifestyle advice, and sent a stool sample to be tested. The results indicated an iron deficiency. The GP referred Mr Brook to a gastroenterology consultant at hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

23. Further tests, including an endoscopy (an internal examination of the digestive tract with a flexible, narrow tube and a small camera), showed no abnormalities in his stomach. Doctors diagnosed anaemia and prescribed iron tablets. Mr Brook's consultant requested a CT scan and colonoscopy of his bowel, which was due to take place on 2 December. Mr Brook refused to go to hospital for the colonoscopy and he signed a disclaimer confirming this.

24. In January 2015, Mr Brook said he had indigestion and prison GPs again referred him under the NHS pathway for cancer. He received an appointment for 4 February 2015, for further investigation of his upper gastric tract. Doctors found no abnormalities. On 25 June, Mr Brook again declined bowel cancer screening.

25. On 30 October, Mr Brook told a prison GP he had felt tired and had lost weight over a long period. He said that for the previous three months, he had experienced pain in his left thigh, during activity. The GP noted Mr Brook looked pale and unwell, so he arranged urgent blood tests. He sent the samples to the hospital by taxi and asked the hospital to ring with the results. The GP also referred Mr Brook to a vascular surgeon. The test results showed Mr Brook had severe anaemia and he was admitted to hospital the same day, for investigation.

26. The hospital took scans of Mr Brook's abdomen, chest, pelvis and left leg. The results showed Mr Brook had terminal bowel cancer that had spread to his lung and a deep vein thrombosis (DVT) in his left leg. On 4 November, Mr Brook's consultant and the palliative care team discussed the diagnosis with Mr Brook and his wife and answered their questions.

27. The clinical reviewer considered that if Mr Brook had consented to the colonoscopy and bowel screening, doctors might have diagnosed his cancer sooner. We cannot know if this would have changed the outcome. We are satisfied that healthcare staff at Hull quickly investigated Mr Brook's symptoms and referred him promptly to hospital specialists.

Mr Brook's clinical care

28. Hospital staff referred Mr Brook to the community Macmillan team, who visited him in hospital. On 10 November, a hospital palliative care nurse telephoned to discuss Mr Brook's diagnosis, care and pain relief. She advised that the palliative care doctor would attend the prison to adjust his pain medication, as necessary. The hospital discharged Mr Brook that day and he was admitted to Hull's wellbeing unit.

29. Prison healthcare staff produced several care plans, which they reviewed and updated as his condition changed. An end of life plan covered all aspects of his care, including access to his cell during the night when all prisoners' cells are usually locked. They created a pain assessment care plan and a mobility and daily living care plan with Mr Brook, who said he wanted to be as independent as possible. The DVT restricted his mobility and he had a manual wheelchair to him get around.

30. On 26 November, at a multidisciplinary meeting about his care, Mr Brook said he did not want to be resuscitated if his heart or breathing stopped. A prison GP completed a form to record this.

31. Healthcare staff monitored Mr Brook's pain every day and prescribed appropriate medication. A hospital palliative care doctor visited to advise on his management and care. Mr Brook retained as much independence as he could. On 5 December, he said that he had changed his mind about resuscitation and, two days later, a prison GP revoked the original agreement.

32. On 4 January 2016, Mr Brook refused to attend a hospital appointment and said he did not want further appointments. As Mr Brook's condition deteriorated, he accepted more help with his personal care. From 18 February, he received daily help with his hygiene. From 20 February, he slept for most of the day.

33. On the morning of 29 February, Mr Brook was drowsy and unable to take his medication. A prison GP examined him and revised his pain relief. At 10.45am, a nurse checked Mr Brook and gave him medication for pain, but an hour later, he declined more. That afternoon, nurses inserted a syringe driver to deliver a steady flow of diamorphine to control his pain.

34. At 6.15pm, a nurse and a healthcare assistant noted Mr Brook's breathing was shallow and then stopped. They found a very weak pulse, so they started cardiopulmonary resuscitation (CPR). The nurse asked an officer to radio a code blue emergency and the control room called an ambulance. (The ambulance arrived at 6.34pm, after Mr Brook's death.)

35. Nurses attached a defibrillator, which found no shockable heart rhythm. A prison GP then arrived and assessed Mr Brook. He asked the nurses to stop the resuscitation attempt and, at 6.29pm, recorded that Mr Brook had died.

36. We are satisfied that Mr Brook received a good standard of care at the prison. Staff were caring and compassionate and Mr Brook's care was equivalent to that he could have expected to receive in the community.

Mr Brook’s location

37. When Mr Brook returned from hospital on 10 November, he was admitted to the prison’s wellbeing unit. On 16 December, he moved to the prison’s palliative care suite, where his wife was able to visit him. On 24 December, security staff agreed that Mr Brook’s cell door should be left unlocked during the night to allow staff easy access if he needed help.

38. On 29 January, after Mr Brook’s health had deteriorated significantly, the prison recommended that he should move to a nursing home, but Mr Brook was adamant that he wanted to go his own home. On 19 February, two nurses from a nursing home assessed Mr Brook for a place at the home but concluded that he was not suitable.

39. Mr Brook remained in the palliative care suite until he died and we are satisfied that his accommodation at the prison was appropriate throughout his illness.

Restraints, security and escorts

40. When prisoners have to travel outside prison, a risk assessment determines the nature and level of security arrangements, including 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. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner’s health and mobility.

41. Before Mr Brook’s cancer was diagnosed, two officers escorted him to hospital appointments and restrained him with handcuffs. After his diagnosis, Mr Brook declined to attend further hospital appointments so restraints were not used again. We are satisfied that security arrangements were proportionate.

Liaison with Mr Brook’s family

42. A Supervising Officer (SO) was Mr Brook’s family liaison officer. The SO visited Mr Brook several times and offered support to him, his wife and family.

43. At 8.20pm on 29 February, the SO and a prison manager visited Mr Brook’s wife at her home to inform her that her husband had died. They offered their condolences and support.

44. Mr Brook’s funeral was held on 16 March and the prison contributed to the costs, in line with national instructions. We are satisfied that prison staff liaised appropriately with Mr Brook’s family.

Compassionate release

45. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness, have a life expectancy of less than three months and fulfil other criteria, including that they have suitable accommodation and they are no longer a risk to the public.

46. On 19 November, a prison GP began an application for early release on compassionate grounds. In December, a prison manager spoke to Mr Brook

about the possibility of release to Probation Service approved premises. Mr Brook told her if he could not go home, he would rather stay in prison. He also dismissed the suggestion of a hospice.

47. On 26 January 2016, the Parole Board reviewed Mr Brook's request, but because of his insistence about his release arrangements, did not recommend early release. A further review was planned in four weeks, subject to Mr Brook's offender manager finding suitable and safe accommodation. Mr Brook died before this took place.

48. We are satisfied that Hull appropriately handled Mr Brook's application for early release.

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