Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Brown a prisoner at HMP Featherstone on 27 March 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*

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 James Brown died on 27 March 2016, of metastatic pancreatic cancer while a prisoner at HMP Featherstone. He was 64 years old. I offer my condolences to Mr Brown's family and friends.

I consider that overall, Mr Brown received a good standard of care at HMP Featherstone, equivalent to that he could have expected to receive in the community. When prison GPs became concerned about his symptoms they referred him for blood tests and further investigations appropriately.

However, I am not satisfied that prison managers authorising the use of restraints, properly considered Mr Brown's health and how this impacted on his risk, although I am pleased to note that restraints were removed some weeks before Mr Brown died.

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

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

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Summary

Events

1. On 23 March 2015, Mr James Brown was remanded to custody and sent to HMP Birmingham. In September 2015, he was sentenced to 32 months in prison. He moved to HMP Featherstone on 25 November.

2. Soon after he arrived at Featherstone, Mr Brown developed significant health problems. By mid-December, Mr Brown's recorded weight was 72kg, down from 80kg from his arrival at Featherstone. The doctor ordered urgent blood tests on 15 December and arranged to see Mr Brown on 22 December to discuss the results. However, the laboratory was unable to complete all of the tests and the doctor re-ordered the missing tests.

3. On 30 December, Mr Brown told a nurse that he had cramping and vomiting within two hours of eating and drinking. Over the following days, his condition deteriorated and a nurse sent him to hospital on 1 January. Tests revealed he had pancreatic cancer. He returned to Featherstone on 12 January 2016 to await surgery, but his health deteriorated further and he was admitted back to hospital on 18 January.

4. Mr Brown remained in hospital. Following surgery on 17 February, hospital doctors gave Mr Brown a prognosis of six to eight months. Mr Brown's health declined quickly and on 17 March, he transferred to a hospice for end of life care. Mr Brown died on 27 March of metastatic pancreatic cancer.

Findings

5. The clinical reviewer considered that the general standard of care that Mr Brown received at Featherstone was good, and equivalent to that he could have expected to receive in the community. However, there was a delay in sending Mr Brown's initial blood samples for testing, which rendered those tests invalid. While the delay did not impact Mr Brown's overall prognosis, it did prevent Mr Brown from receiving earlier diagnosis of his condition and treatment of his symptoms. The prison has since arranged additional collection times for samples to prevent such a delay occurring in the future.

6. On the two occasions Mr Brown went to hospital, prison managers approved the use of restraints. While we understand that the prison considered Mr Brown remained a high risk to the public despite his health condition, we are not satisfied that there was sufficient healthcare input into the risk assessment process for managers to make a fully informed decision.

7. Mr Brown's next of kin was with him when he died, but we were concerned that the prison family liaison officer waited two days following Mr Brown's death before contacting her to offer condolences and support. This is not in line with national instructions.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that prisoners' families are informed promptly and in person when a prisoner dies, and are offered appropriate support in line with Prison Service Instructions.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Featherstone 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 Brown's prison and medical records.

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

11. We informed HM Coroner for Staffordshire South 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 Brown's ex-partner, his nominated next of kin, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She raised no concerns and told us that she considered Mr Brown received a good standard of care from the prison.

13. The investigation has assessed the main issues involved in Mr Brown'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 did not find any factual inaccuracies.

15. Mr Brown's ex-partner was informed the initial report was available, but did not wish to receive a copy or make any comment.

Background Information

HMP Featherstone

16. HMP Featherstone is a medium security prison that holds nearly 700 men. At the time of Mr Brown's death, Staffordshire and Stroke on Trent Partnership NHS Trust provided healthcare services. Doctors consult at the prison from Monday to Friday. There are nurse led clinics for chronic conditions, substance misuse and mental health. From 1 April 2016, Care UK took over as the provider of healthcare services. There are no inpatient facilities at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Featherstone was in October 2013. Inspectors reported that, although overall clinical care was good, prisoners sometimes waited too long for an appointment, with many external hospital appointments cancelled owing to a lack of escort staff.

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. In its latest annual report, for the year to October 2015, the IMB reported that despite considerable improvements to services provided by the healthcare department, there were concerns over issues relating to cancellation of appointments at outside hospitals.

Previous deaths at HMP Featherstone

19. Mr Brown was the first prisoner to die from natural causes at Featherstone since January 2014.

Findings

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

20. On 23 March 2015, Mr James Brown was remanded into custody charged with blackmail and sent to HMP Birmingham. He was sentenced to 32 months in prison on 21 September 2015. He moved to HMP Featherstone on 25 November 2015.

21. A nurse carried out Mr Brown's initial health screen when he arrived at Featherstone. She recorded his weight at 80kg and noted that he suffered with type two diabetes and heart disease for which he took medication. He also had pain associated with an incorrectly healed bone fracture. A GP prescribed Mr Brown's medications.

22. On 14 December, Mr Brown attended the diabetes clinic and told a nurse of problems urinating for the previous six months and weight loss. She considered possible prostate problems and made an appointment for Mr Brown to see a doctor the next day. She recorded his blood pressure, blood glucose and oxygen saturation as within the normal range and his weight at 73kg.

23. A prison GP saw Mr Brown the next day. Mr Brown complained of lower back pain, difficulty urinating and weight loss. The GP requested urgent blood tests and made an appointment to review the results with Mr Brown on 22 December. A nurse took the blood sample at 11.20am and the sample went to the laboratory at approximately 4.00pm (which was the normal collection time for blood samples). However, the laboratory was unable to complete all the tests because the blood sample had been left too long before being tested. The available results indicated minor abnormalities in Mr Brown's white blood cell count, but did not raise clinical concerns. On 22 December, the GP requested repeat blood samples for the missing tests and recorded Mr Brown's weight at 72kg.

24. On 30 December, Mr Brown told a nurse that he had suffered with abdominal cramping for the last two months, and vomiting for the previous six days. She explained that the available blood test results raised no concerns and that a doctor would discuss the results from the repeated blood tests with him at a pre-arranged appointment on 5 January 2016. She recorded his weight at 69kg.

25. On 1 January 2016, Mr Brown told the nurse that he had continued to vomit and had pain in his abdomen. She noted that the skin around his eyes was jaundiced and his health had deteriorated. She arranged for an emergency ambulance to hospital. The hospital admitted Mr Brown and performed an endoscopy (an internal examination of the body, using a long thin flexible tube with a camera attached). The endoscopy identified that Mr Brown had a cancerous tumour blocking the discharge of bile from his pancreas and doctors fitted a stent to drain the bile. Hospital doctors informed Mr Brown of the diagnosis and that he would need surgery to remove the tumour.

26. The clinical reviewer noted that on 15 December, Mr Brown's symptoms and weight loss may have justified an urgent referral to a specialist. However, the clinical reviewer says that the prison GP's decision to request urgent blood tests

with a follow up appointment was in line with national guidelines and consistent with community healthcare practices.

27. We also note that, if all the blood tests results had been available on 22 December, they were likely to have triggered an earlier admission to hospital. While it would not have affected the outcome for Mr Brown, because of the advanced nature of his condition, the delay prevented him from receiving earlier treatment of his symptoms.

28. The Head of Healthcare told us that blood samples were usually collected for the laboratory once a day at 4.00pm, which meant that any samples taken in the morning would be several hours old when the laboratory received them. Following this investigation the prison arranged an additional collection time of 12.00pm each day. We are satisfied that this additional collection will reduce problems with testing blood samples in future and therefore do not make a recommendation.

Mr Brown's clinical care

29. On 12 January, the hospital discharged Mr Brown back to prison to await surgery at hospital.

30. During an assessment on 14 January, Mr Brown complained of pain and nausea. A nurse contacted a Macmillan specialist to discuss options to support Mr Brown. They agreed to involve Macmillan after Mr Brown's surgery.

31. On 18 January, Mr Brown reported nausea, vomiting and severe stomach pains. In discussion with the consultant at hospital, healthcare staff arranged for admission back to hospital that day. While in hospital Mr Brown received food and fluids through a drip and a feeding tube, but remained mobile and mostly self-caring.

32. Mr Brown remained in hospital and, on 8 February, he moved to hospital where he underwent the planned surgery. On 17 February, hospital doctors informed Mr Brown that the cancer had spread and his life expectancy was between six to eight months. On 23 February, a nurse discussed Mr Brown's condition with hospital staff, who advised that Mr Brown was too unwell to be discharged back to prison. On 7 March, a nurse and healthcare staff visited the hospital to re-assess Mr Brown's condition. They assessed that Mr Brown was self-caring and recommended exploring options for discharge to Featherstone.

33. Over the next few days, Mr Brown's health declined. On 10 March, senior prison managers met a nurse to discuss options for Mr Brown's care. They agreed that, given his deteriorating health, Mr Brown should move to a hospice.

34. On 17 March, Mr Brown was transferred to a hospice. Mr Brown's condition continued to deteriorate and he died at 8.20pm on 27 March. A post-mortem examination showed that Mr Brown died of metastatic pancreatic cancer (cancer of the pancreas that has spread to other parts of the body).

35. We are satisfied that Mr Brown's clinical care was good at Featherstone. Staff arranged for him to return to hospital when it was clear his condition was

deteriorating. There was good liaison with specialists and the hospital and his care was equivalent to that he could have expected to receive in the community.

Mr Brown's location

36. Featherstone does not have any inpatient facilities and while there Mr Brown was in a single cell on a normal wing. Nurses visited him every day to monitor his condition.

37. While Mr Brown was in hospital in February, healthcare staff at Featherstone contacted HMP Birmingham to discuss the possibility of a transfer for Mr Brown to their palliative care suite. Healthcare staff from Birmingham assessed Mr Brown but on 23 February, Mr Brown told a nurse that he wanted to remain in Featherstone to be closer to his next of kin.

38. As Mr Brown's condition deteriorated and it became clear that he could not return to Featherstone, healthcare staff arranged for him to move to a hospice. We are satisfied that the prison appropriately located Mr Brown and considered his wishes.

Restraints, security and escorts

39. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment 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.

40. Mr Brown went to hospital on 1 January and 18 January 2013. For both periods in hospital, a prison manager approved the use of handcuffs on the way to hospital and an escort chain while in hospital (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).

41. The risk assessments showed that the prison considered Mr Brown was a high risk to the public (his offence had been against vulnerable adults) and of escape. Healthcare staff did not raise any objections to the use of restraints by ticking a box on the risk assessment form, but gave no further details of Mr Brown's condition or its impact on his risk of escape. After Mr Brown's prognosis on 17 February, a senior prisoner manager authorised officers to remove the escort chain and it was not reapplied.

42. Mr Brown's mobility in the period leading to 17 February varied considerably. Although, he self-cared, he required a feeding tube and frequently received medication for pain relief. While these aspects of Mr Brown's treatment restricted his capacity to move, he maintained a degree of mobility and the prison considered he remained a high risk to the public. However, the 2007 High Court

judgement makes it clear that a medical opinion about the prisoner's ability to escape must be considered as part of the risk assessment process. We are not satisfied that there was sufficient healthcare input into the risk assessment for managers to make an informed decision. We are pleased that restraints were removed several weeks before Mr Brown's death. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Brown's family

43. Mr Brown was in contact with his ex-partner, his nominated next of kin, and had informed her of his condition. On 21 March, the prison appointed a Supervising Officer (SO) as Mr Brown's family liaison officer.

44. Mr Brown's ex-partner was in contact with the hospice and was with him when he died. The SO telephoned Mr Brown's ex-partner on 29 March, two days after his death, to offer her condolences and support.

45. Mr Brown's funeral was on 21 April 2016. The prison arranged and paid for the funeral, in line with national policy.

46. Prison Service Instruction (PSI) 64/2011 'Safer Custody' requires prisons to contact a deceased prisoner's next of kin as soon as possible after death and, where possible, this contact should be face-to-face. While Mr Brown's next of kin was with him when he died, we consider that the prison unnecessarily delayed contacting her to offer condolences and support, and that the contact should have been in person. We make the following recommendation:

The Governor should ensure that prisoners' families are informed promptly and in person when a prisoner dies, and are offered appropriate support in line with Prison Service Instructions.

Compassionate release

47. 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 and have a life expectancy of less than three months. 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, and that 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).

48. The prison started an application for compassionate release for Mr Brown on 11 March 2016. The hospital consultant noted that Mr Brown received palliative care and had a limited life expectancy. The governor supported the application

but Mr Brown's offender manager and probation officer did not support his release. They were concerned there was no family support and that Mr Brown posed too high a risk to the public. The prison submitted the application to the PPCS on 16 March.

49. On 23 March, the PPCS rejected the application because with no family to care for him, release did not create significant benefits for Mr Brown, and he could not be safely managed on licence.

50. We are satisfied that the prison appropriately considered and applied for compassionate release for Mr Brown.

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