Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Lee a prisoner at HMP Bure on 27 May 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Michael Lee died of pneumonia in hospital on 27 May 2016. Mr Lee was 53 years old. I offer my condolences to Mr Lee's family and friends.

Mr Lee had tuberculosis and lung cancer, and received treatment for both. He went to hospital as an emergency on 15 May, because he was unwell. While there, he developed a blood clot in his right leg and had an operation to remove it. The operation was unsuccessful, and Mr Lee had the leg amputated. His health deteriorated, and he died on 27 May. The care Mr Lee received at HMP Bure was equivalent to that he could have expected to receive in the community. However, I am concerned to see that a very ill and immobile man was restrained. This is not the first time that I have raised this issue with Bure and I am disappointed that I have to do so again.

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 **December 2016**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Key Events 4
Findings 6

Summary

Events

1. Mr Michael Lee was sentenced to 18 years imprisonment for sexual offences on 1 June 2007. He spent time in two prisons before being admitted to HMP Bure on 16 December 2011. He suffered from high blood pressure, liver damage, asthma and had a history of heart issues. Mr Lee had poor mobility as the result of a stroke and had mental health issues. He received medications for these in prison.

2. In July 2015, Mr Lee complained to a nurse of a persistent cough. An x-ray showed an infection, possibly related to tuberculosis (TB). Further investigations confirmed, in December, that he had TB and lung cancer.

3. On 30 March 2016, Mr Lee had a tumour removed from his lung. The operation was a success so he returned to prison and hospital consultants planned for chemotherapy. Before this could happen, Mr Lee became ill, breathing with difficulty. His oxygen level was very low and prison healthcare staff sent him to hospital on 15 May. While in hospital, doctors diagnosed pneumonia, which they treated with antibiotics. A life threatening blood clot developed in Mr Lee's right leg, and he had an operation to remove it on 19 May. This was not successful, and he had to have the leg amputated to above the knee on 20 May. Hospital doctors sedated him to help him recover but he never regained consciousness. He died on 27 May.

Findings

4. The clinical care Mr Lee received at HMP Bure was equivalent to that he could have expected to receive in the community. Doctors diagnosed the lung cancer promptly, and appropriately sent him to hospital.

5. However, when Mr Lee went to hospital as an emergency on 15 May, he was inappropriately restrained, although the restraints were removed four days later. The initial risk assessments did not fully take into account Mr Lee's risk given his very poor health and limited mobility.

6. Mr Lee's nominated next of kin, a friend, was complimentary about contact with the liaison officer, although contact was delayed because the prison had recorded the incorrect contact details.

Recommendations

- The Governor 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 the next of kin of seriously ill prisoners are contacted as soon as possible, and that there is no unnecessary delay.

The Investigation Process

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

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

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

10. We informed HM Coroner for Greater Norfolk District of the investigation who gave us the results of the post-mortem examination. We have given the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Lee's friend to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He said that the care Mr Lee received at the prison was good but felt that he should have been contacted earlier about Mr Lee's condition.

12. Mr Lee's friend received a copy of the initial report. They did not make any comments.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Bure

14. HMP Bure is a medium security prison near Norwich, which holds over 600 men, convicted of sexual offences.

15. Virgin Care provides healthcare services. Healthcare staff are on duty between 8.00am and 7.30pm on weekdays and between 8.00am and 6.00pm at weekends. Five GP clinics are scheduled each week. There is an out of hours service.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Bure was in May 2013. Inspectors reported that prisoners were positive about healthcare services and there was a good range of nurse-led clinics. Provision for older prisoners was well developed. Some cells were adapted for prisoners with mobility problems and to allow wheelchair access.

Independent Monitoring Board

17. 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 the healthcare department was improving, with the introduction of a new out of hours healthcare provision contract, and a contract for non-locum GPs.

Previous deaths at HMP Bure

18. Mr Lee was the fourth prisoner to die of natural causes at Bure since January 2015. We have made recommendations regarding risk assessments for the use of restraints before.

Key Events

19. Mr Michael Lee was sentenced to 18 years imprisonment on 1 June 2007 for sexual offences. He spent time in two prisons, before being transferred to HMP Bure on 16 December 2011. At his initial health screen, a nurse noted that he used glyceryl trinitrate spray (GTN spray – to relieve angina pain) and inhalers (for asthma). He had high blood pressure, and liver damage caused by drug and alcohol dependency, though he had been sober for six years. In 2005, he had suffered a stroke and now used a walking stick to help him walk and, in 2006, he had a heart attack. He sometimes suffered from breathlessness. He also had mental health issues. Doctors prescribed Mr Lee several medications to treat his physical and mental health.

20. Over the next few years, Mr Lee saw healthcare staff when he needed to and received his medications. On 8 July 2015, Mr Lee told a nurse that for three months, he had suffered from a cough which produced brown sputum, although he did not feel ill. She noted he was an ex-smoker and took his observations. His oxygen level (98%) and heart beat (64 beats per minute) were within normal range. She referred him for a chest x-ray. The results of the x-ray, on 17 July, showed a chest infection, possibly related to previous tuberculosis (TB – a bacterial lung infection) and hospital doctors prescribed antibiotics. A prison GP reviewed Mr Lee on 7 August, and ordered a repeat chest x-ray. He also ordered Mr Lee to give six sputum samples, over the next ten days, to test for TB.

21. A TB specialist nurse contacted the prison, on 2 September, to report that something was growing on Mr Lee's lung. A chest x-ray on 22 September confirmed that there were masses in both of his lungs and the hospital referred him urgently, on 30 September, to the respiratory clinic.

22. At the urgent appointment on 14 October, the consultant did not consider Mr Lee's symptoms to be typical of lung cancer, and planned further tests. After a CT scan and blood tests in October, then a bronchoscopy (when a small camera is inserted into the lungs to examine them) in November, it was thought Mr Lee had both lung cancer and TB. A biopsy on 15 December confirmed this, and the consultant told Mr Lee on 24 December. He had cancer in his left lung, and TB. He received medications to treat TB.

23. A hospital consultant assessed Mr Lee for an operation on his lung. He had the operation in hospital on 30 March 2016, and returned to prison on 5 April. He went to hospital twice in April as an emergency, after becoming unwell. Hospital doctors diagnosed him, first, with a chest infection, and then with suffering side effects of the antibiotics they had prescribed.

24. The hospital consultant saw Mr Lee on 9 May, and informed him that the lung cancer had been successfully removed, and made a plan to begin chemotherapy in three weeks. Before this happened, Mr Lee became ill on 15 May. A nurse saw him in his cell because he was finding it hard to breathe. She sent him to hospital as an emergency, as his oxygen level was low (78%). Two escort officers accompanied him, and they restrained him with 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). He needed a wheelchair to get around.

25. Hospital doctors diagnosed Mr Lee with pneumonia. His health deteriorated and on 19 May, he had an operation to remove a life threatening blood clot in his right leg. Officers removed the escort chain for the operation, and they did not restrain Mr Lee subsequently. Hospital doctors told Mr Lee that he had a 50% chance of recovery, and his leg may need amputating if the operation did not work. The operation was not successful and, on 20 May, Mr Lee had another operation to amputate his leg. Doctors placed Mr Lee in a medically induced coma and he never regained consciousness. His health deteriorated and the hospital began palliative care on 25 May. A doctor confirmed Mr Lee's death at 10.10am on 27 May.

Contact with Mr Lee's family

26. Mr Lee nominated a friend as his next of kin. The prison appointed family liaison officers on 18 February 2016. Initially, Mr Lee did not request that his next of kin, his friend, be contacted by the family liaison officers, and was able to keep in contact himself. While in hospital on 19 May, Mr Lee requested that a family liaison officer contact his friend to update them on his situation. They first tried to contact Mr Lee's friend on 19 May but were not successful. A family liaison officer attempted to make contact over the next few days, but repeatedly got through to an answer phone. On 22 May, she found, through the prison record, that the number she had for the next of kin was incorrect. With the correct number, she was able to phone and speak with Mr Lee's friend. Mr Lee's friend and his wife visited Mr Lee in hospital on 25 May and agreed to be told over the phone when Mr Lee died. Another family liaison officer told them on 27 May when Mr Lee died.

27. Mr Lee's funeral was on 27 June. The prison arranged and paid for the funeral, in line with national protocol.

Support for prisoners and staff

28. After Mr Lee's death, a prison manager debriefed the staff who had been at the hospital with Mr Lee to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

29. The prison posted notices informing other prisoners of Mr Lee's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Lee's death.

Post-mortem report

30. The post-mortem concluded that Mr Lee died of pneumonia. He developed a clot that blocked the circulation to his right leg in hospital, and he had an above knee amputation. It noted his previous operation on his lung, and anti-TB treatment, but these were not contributing factors to his death.

Findings

Clinical care

31. The care that Mr Lee received was equivalent to that he could have expected to receive in the community. The clinical reviewer concluded that HMP Bure referred him appropriately for secondary care when he had respiratory symptoms. He had a successful operation to remove lung cancer and recovered well. Unfortunately, he developed pneumonia before chemotherapy was started to treat lung cancer.

Restraints, security and escorts

32. 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.

33. Mr Lee was sent out to hospital on 15 May. A member of healthcare staff wrote in the risk assessment that they had no objection to the use of restraints, but they were likely to need removing as it would probably become a longer stay in hospital. Prison security assessed Mr Lee as a low risk of escape and of harm the public. A prison manager authorised use of an escort chain, while noting Mr Lee was wheelchair bound. On 19 May, when Mr Lee had the first operation on his right leg, escort officers removed the restraints, which they did not reapply.

34. We are pleased that managers reviewed the risk and removed Mr Lee’s restraints four days after the hospital admitted him, and once they operated on him. However, when he first went to hospital, Mr Lee was very ill with very low oxygen levels. His mobility was very poor, to the extent that he needed a wheelchair. We are not satisfied that the risk assessment properly took into account how Mr Lee’s health affected his already low risk of escape. We make the following recommendation:

    The Governor 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.

Family liaison

35. When Mr Lee went to hospital in May, he did not initially ask for the liaison officers to contact his next of kin. When he did, his next of kin’s phone number was recorded incorrectly in prison records. It took three days for one of the family liaison officers to identify and correct the error.

36. Following this, the family liaison was good, and Mr Lee's friend was complimentary about the contact he had with the liaison officers. However, the prison should ensure they have the correct telephone number for prisoners who are seriously ill. If they had been able to make initial contact, his friend may have been able to visit Mr Lee before hospital doctors placed him in a coma. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are contacted as soon as possible, and that there is no unnecessary delay.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141