Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Eastwood a prisoner at HMP Hull on 4 September 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*

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 Matthew Eastwood died on 4 September of prostate cancer that had spread to other parts of the body while a prisoner at HMP Hull. He was 57 years old. I offer my condolences to those who knew him.

I am satisfied that Mr Eastwood received a good standard of care at Hull, equivalent to that he could have expected to receive in the community. However, I am concerned that managers authorised the use of restraints when Mr Eastwood went to hospital without properly considering his health at the time. I have raised this issue with the prison in previous reports.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2017**

Contents

Summary

Events

1. On 15 April 1987, Mr Matthew Eastwood was convicted of murder and sentenced to life in prison. He was moved to HMP Hull on 20 September 2013.

2. On 23 April 2015, Mr Eastwood reported back and leg pain. A prison doctor diagnosed lumbago (lower back pain) and prescribed pain killers. The pain continued and, on 5 May, he attended a local clinic for an ultrasound scan (a scan that uses high frequency sound waves to build up a picture of the inside of the body). The scan identified abnormal looking lymph nodes (an oval- or kidney-shaped organ of the lymphatic system, present widely throughout the body) in his groin and staff at the clinic arranged a follow up hospital appointment.

3. On 6 May, Mr Eastwood was admitted to hospital for further tests. The tests identified that he had prostate cancer that had also spread to his bones. He began hormonal therapy and palliative radiotherapy before returning to prison on 22 May.

4. The prison healthcare team continued to care for Mr Eastwood, under the coordination of his hospital oncologist and the palliative care team. Staff put appropriate care plans in place and he attended regular hospital appointments. In June 2016, he began chemotherapy treatment. Despite the efforts of prison healthcare and hospital staff, his pain often proved difficult to manage.

5. In July, Mr Eastwood noticed blood in his urine, a sign that his condition had progressed. His health continued to deteriorate and, on 18 August, a prison doctor arranged his hospital admission. While in hospital, doctors determined that Mr Eastwood only had weeks to live and they stopped providing active treatment. His condition deteriorated further and he died on 4 September.

Findings

6. The clinical reviewer considered that the care Mr Eastwood received at Hull was equivalent to that he could have expected to receive in the community. We are satisfied that Mr Eastwood received good care at the prison.

7. However, we are concerned that managers authorised the use of restraints when Mr Eastwood went to hospital without taking into account his condition at the time and how this impacted on his risk.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 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 Eastwood's prison and medical records.

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

11. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. Mr Eastwood had not named anyone as his next of kin and enquiries after his death did not identify any family.

13. The investigation has assessed the main issues involved in Mr Eastwood's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, and whether compassionate release was considered.

14. We shared the initial report with the Prison Service who identified two factual inaccuracies. We have amended the report accordingly. The Prison Service submitted an action plan in response to our recommendation and this is appended to this report

Background Information

HMP Hull

15. HMP Hull is a local prison, which holds up to 1056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison closed its healthcare inpatient unit in October 2014, which became the Wellbeing unit to support and progress prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hour's service at other times.

HM Inspectorate of Prisons

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

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 2015, the IMB noted that the prison is effectively run, provides a safe environment for all and has benefited from the strong leadership of the current Governor and Management Team.

18. The IMB noted that there was a full health screen at reception, which identified immediate risks and outpatient clinics to manage long term medical conditions. However, the Board had received many complaints, mostly concerning medication and prescribing issues.

Previous deaths at HMP Hull

19. Mr Eastwood's death was the sixth from natural causes at Hull since January 2015. We have raised the issue of the need for properly considered risk assessments to justify the use of restraints in previous investigation reports.

Findings

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

20. On 15 April 1987, Mr Matthew Eastwood was convicted, in his previous name (Mr Richard James Small), of murder and sentenced to life in prison. He was moved to HMP Hull on 20 September 2013.

21. Mr Eastwood had a history of medical issues including asthma, high blood pressure, high cholesterol, angina (severe chest pain caused by inadequate blood supply to the heart), osteoarthritis (stiff, painful joints) and deep vein thrombosis (DVT – a blood clot that develops within a deep vein). He also suffered from a personality disorder and anxiety, and had a history of drug abuse and self harm. Mr Eastwood took prescribed medication and healthcare staff introduced care plans to manage his various conditions.

22. On 23 April 2015, a prison GP examined Mr Eastwood after he reported back and leg pain. The doctor diagnosed lumbago (lower back pain) and prescribed amitriptyline, an antidepressant used to relieve the pain of arthritis and related conditions. He told Mr Eastwood to come back if his condition deteriorated.

23. On 5 May, a nurse examined Mr Eastwood. His left leg was swollen and painful to touch. Because he had a history of DVT, staff arranged for him to go to a local clinic for an ultrasound scan that afternoon. The scan showed no clinical evidence of DVT though it identified abnormal looking lymph nodes in his groin. A follow up hospital appointment was made for 12 May to allow further investigations.

24. Mr Eastwood returned to Hull that evening but continued to be in pain. At around 11.30pm, Mr Eastwood told a nurse that the pain in his groin had not gone and he had numbness in his left testicle and penis. The nurse examined him and noted the area appeared swollen and firm to touch. She arranged for him to go to hospital for further assessment and called a non-emergency ambulance.

25. However, at 0.30am on 6 May, before the ambulance had arrived, Mr Eastwood rang his cell bell and told staff he had taken an overdose of his in possession painkillers, as he knew staff would have to do something about it. A nurse attended and gave him carbomix (used for the emergency treatment of acute oral poisoning or drug overdose). The ambulance arrived shortly afterwards.

26. Mr Eastwood was admitted to Castle Hill Hospital, Cottingham, where he underwent further tests and investigation. Prison healthcare staff kept in regular contact with the hospital regarding his treatment, diagnosis and discharge.

27. On 19 May, a hospital consultant reviewed Mr Eastwood and confirmed that a computed tomography scan (CT scan, uses x-rays to make detailed pictures of parts of the body) and subsequent lymph node biopsy had confirmed a diagnosis of metastatic prostate cancer. The consultant arranged for Mr Eastwood to receive hormonal therapy (which can shrink the cancer, delay its growth and reduce symptoms) and palliative radiotherapy (used to control symptoms and

give a better quality of life) to his spine. The consultant noted in Mr Eastwood's medical records that he was fully aware of his diagnosis and plan.

28. On 20 May, a Macmillan nurse confirmed that Mr Eastwood was distressed about his diagnosis and he still wanted staff to attempt to resuscitate him if his heart or breathing stopped. Later that day, a multi disciplinary team discussed Mr Eastwood's ongoing care. There is no indication in the medical notes to confirm whether or not he was present.

29. On 21 May, a hospital doctor spoke to a nurse to discuss his medication, in particular pain control during the night, as they planned to discharge Mr Eastwood the next day. The doctor reiterated that Mr Eastwood's prostate cancer had spread to his bones. The doctor said they intended to see Mr Eastwood in three months. He continued to have hormone injections but no additional treatment.

30. Another Macmillan nurse saw Mr Eastwood in hospital on 22 May. They discussed his condition and pain relief. The nurse referred him to the community Macmillan team for ongoing symptom management.

31. The hospital discharged Mr Eastwood back to prison later that day and he was admitted to the prison's Wellbeing unit. A nurse recorded the details from his discharge notes into his medical records, including medication, pain relief and follow up appointment. Staff completed a full assessment of his needs and created appropriate care plans.

32. We agree with the clinical reviewer that as Mr Eastwood's condition deteriorated, there was appropriate identification, assessment and subsequent referral to the secondary care provider.

Mr Eastwood's clinical care

33. On 27 May, a nurse telephoned the Macmillan team to arrange a review as, after speaking with him, Mr Eastwood appeared unclear about his full diagnosis and treatment. After making enquiries with his oncology consultant, a Macmillan nurse confirmed that Mr Eastwood would continue to have hormone therapy treatment, with the next injection due on 10 June.

34. On 1 June, a third Macmillan nurse, asked another nurse about Mr Eastwood's pain, who said it was well controlled and that he had moved back to a normal wing. The second nurse said that she did not consider continued input from Macmillan staff necessary at that time, so the Macmillan nurse removed Mr Eastwood from their caseload but stressed that the prison should contact them if things changed.

35. Healthcare staff continued to see Mr Eastwood regularly to assess his pain. He did not raise any concerns. However, on 25 June, a nurse responded after discipline staff found him collapsed on his cell floor. His skin was grey, cold and clammy. Staff called an ambulance and Mr Eastwood went to hospital where they admitted him overnight.

36. Mr Eastwood returned to prison the next day but refused to take any medication or to accept any in possession medication. He told staff that the way he felt

physically he might take all his in possession medication at once, though he denied any thoughts of suicide.

37. On 27 June, a nurse examined Mr Eastwood after he made a number of superficial cuts to the inside of his arms. Mr Eastwood said he wanted to go to hospital because of the pain following the removal of his catheter. Staff readmitted him to the Wellbeing unit and referred him to the mental health team. They also placed him on an ACCT plan, the Prison Service's care-planning system used to support prisoners at risk of suicide or self-harm, which was closed on 1 July, as they were satisfied that he no longer presented a risk.

38. On 10 July, a nurse examined Mr Eastwood after he reported pain and swelling in his left leg and abdomen. The nurse sent him to Castle Hill Hospital, where he was admitted. Healthcare staff stayed in regular contact with the hospital regarding his condition and referred him back to the Macmillan Unit.

39. On 20 July, a Macmillan nurse reviewed Mr Eastwood in hospital. She amended his painkiller medication and arranged a follow up in the Palliative Care clinic. The hospital discharged Mr Eastwood back to prison on 22 July.

40. A Macmillan GP reviewed Mr Eastwood in prison on 30 July, following the earlier referral. The doctor noted that his response to treatment was encouraging and that his pain was now adequately controlled. Mr Eastwood later told a nurse that the doctor had answered his questions and he felt reassured.

41. Healthcare staff continued to see Mr Eastwood regularly to monitor his condition, pain control and mental health. He remained relatively stable but told staff his moods fluctuated following his diagnosis.

42. On 12 November, a doctor referred Mr Eastwood to DVT services after he reported further swelling to his left leg. He underwent tests but all were negative. However, his leg remained swollen and painful and, on 5 January 2016, he asked to see the doctor. A doctor saw him the next day and arranged an MRI scan (Magnetic Resonance Imaging, a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body).

43. Mr Eastwood continued to have pain and swelling in his leg and groin. On 15 February, he attended the Westbourne DVT clinic where tests showed swollen lymph nodes in his groin. He returned to prison and, the next day, a doctor agreed to contact his oncologist for advice. The doctor later increased his pain relief medication and healthcare staff contacted the Macmillan team regarding additional support.

44. Later that afternoon, healthcare staff responded to an emergency call after Mr Eastwood made a number of small cuts to his inner thigh. A nurse cleaned and dressed his wounds. Mr Eastwood told him that he wanted to go to hospital and did not want to see the prison doctor. Staff opened an ACCT and took all of Mr Eastwood's in possession medication from him. He did not go to hospital but a doctor saw him the next day.

45. On 18 February, at a multidisciplinary team meeting, Mr Eastwood told staff that, following his diagnosis and the recent death of his foster mother, he found it

difficult to cope and had become frustrated. He asked for an extra mattress and comfortable chair to assist his pain relief, which the prison provided.

46. Healthcare staff continued to care for Mr Eastwood together with his oncology consultant, the Macmillan team and the mental health team. He attended regular hospital appointments. On 25 April, his consultant told him his cancer had progressed. They discussed chemotherapy treatment but the consultant did not arrange it at that time. On 2 May, staff assessed Mr Eastwood for and issued him with a wheelchair. On 23 May, he returned to a cell in the Wellbeing unit. A nurse saw him the next day and he told her he had his pain under control and felt settled.

47. Mr Eastwood went out to hospital on 3 June, for a pre-planned appointment. He began a three month chemotherapy treatment plan the next day. Healthcare staff created chemotherapy and pain care plans.

48. Mr Eastwood took his medication as prescribed. Healthcare staff continued to monitor his condition, particularly regarding pain management and any side effects from his chemotherapy. He often reported feeling nauseous.

49. On 23 July, Mr Eastwood told a nurse that he had seen blood when passing urine. The nurse checked his vital signs, which were normal, and took a sample of urine for analysis. The doctor examined him on 25 July and found that he did not have blood in his urine but had a fungal rash on his groin.

50. On 27 July, Mr Eastwood saw his oncologist who stopped his chemotherapy treatment for seven days. They planned to begin it again after that time for a period of one month following which they would decide whether or not to continue. His next appointment was arranged for 28 August.

51. On 11 August, Mr Eastwood told a nurse he had a lot of blood in his urine and felt very unwell. The nurse saw his urine bottle which appeared to contain a large quantity of blood. A doctor was nearby and explained to Mr Eastwood that his symptoms were to be expected as his illness progressed and that there was little they could do for him in hospital. Mr Eastwood believed he had eight to ten years to live. The doctor told him that the average life span was about three years, but that this was difficult to predict. Mr Eastwood went to hospital for examination but they did not admit him and he returned to prison that evening.

52. On 14 August, a nurse reviewed Mr Eastwood, who said his legs were numb and he could not take his medication due to nausea and vomiting. The nurse monitored Mr Eastwood throughout the day and, when his condition did not improve, she contacted the out of hours GP who prescribed antiemetic (anti sickness) medication. Healthcare staff monitored him throughout the night and over the next few days but he continued to deteriorate.

53. A doctor examined Mr Eastwood on 18 August, and noted that he did not look well. He had constant pain in his legs, scrotum, penis and abdomen. The doctor arranged for his admission to Castle Hill Hospital.

54. Healthcare staff maintained regular contact with the hospital. On 25 August, a nurse discussed Mr Eastwood's discharge with hospital staff who told her his condition was terminal and he had, at most, only a few weeks to live. Hospital

staff kept him comfortable and managed his pain but he no longer received active treatment.

55. Senior prison managers, hospital, healthcare and palliative care team staff agreed that Mr Eastwood was too ill to move and he remained in hospital until his death on 4 September, from bilateral bronchopneumonia and disseminated metastatic tumour due to prostatic carcinoma.

56. The clinical reviewer was satisfied that Mr Eastwood received a good standard of medical and nursing care at Hull, equivalent to that he would have received in the community. We also agree that healthcare staff appropriately supported Mr Eastwood following his diagnosis and through his transition to palliative care.

Mr Eastwood's location

57. For the majority of his time at Hull, Mr Eastwood lived in a single cell. Between 22 May and 1 June 2015, Mr Eastwood lived in the Wellbeing unit for high dependency patients or those receiving palliative care. When in the Wellbeing unit, Mr Eastwood lived in the palliative care cell, a large specially adapted cell with a hospital bed and mattress.

58. When Mr Eastwood's health began to deteriorate, he returned to the Wellbeing unit on 23 May 2016. Staff kept his cell door open during the day but locked it at night. He had not reached the stage where healthcare staff needed a 24-hour open door policy. Mr Eastwood remained in the Wellbeing unit until 18 August, when he was admitted to hospital.

59. We are satisfied that staff considered Mr Eastwood's wishes and that he was located appropriately.

Restraints, security and escorts

60. 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, the Graham judgment, 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.

61. In 2016, Mr Eastwood attended a number of hospital appointments and spent time in hospital. Two officers accompanied him each time and, initially, despite being assessed as low risk (medium risk to the public), they restrained him with double cuffs. (Double cuffs are when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs).

62. A prison manager completed a risk assessment on each occasion that Mr Eastwood went out to hospital. They continued to assess the risk he presented as low. On each occasion, the assessment included input from a member of the healthcare team who did not object to the use of restraints. However, there is no information about how Mr Eastwood's medical condition affected his ability to escape or the risk he presented at the time.

63. In February 2016, the use of double cuffs was reduced to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). By this time, Mr Eastwood needed to use a wheelchair for anything more than short walks.

64. When Mr Eastwood's condition deteriorated and he was admitted to hospital on 18 August, he was kept on an escort chain for four days until a senior prison manager authorised its removal.

65. We are pleased to see that the prison continually assessed the risk Mr Eastwood presented and that restraints were eventually removed. However, it does not appear that his medical condition and its effect on his ability to escape was properly considered. 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 on the use of restraints 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 Eastwood's family

66. Mr Eastwood had no known next of kin, as his foster mother died in January 2016.

67. In prison, Mr Eastwood had a close friend, who he described as being like a brother and the only significant person in his life. However, Mr Eastwood did not nominate his friend as his next of kin. On 26 August, the prison arranged for his friend to visit him in hospital.

68. Following Mr Eastwood's death, the prison contacted his friend to tell him that Mr Eastwood had died and to offer their condolences and support.

69. The prison arranged and paid for Mr Eastwood's funeral, which took place on 28 September 2016.

Compassionate release

70. Prisoners can be released from custody 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.

71. On 24 August 2016, a multi disciplinary panel, chaired by a senior prison manager, assessed Mr Eastwood's suitability for early release. At that time, Mr

Eastwood was an inpatient at Castle Hill Hospital and staff did not consider his discharge imminent.

72. Mr Eastwood had no family links outside of prison and did not meet the criteria for a social care package. He had not completed the extended Sexual Offences Treatment Programme and as such, despite his illness, the panel still believed he presented a risk. The prison Governor did not consider him suitable for compassionate release.

73. On 31 August, the panel reviewed and confirmed their decision, there being no real change in circumstances. They planned a further review for 7 September, but Mr Eastwood died before this took place. We are satisfied that compassionate release was appropriately considered.

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