

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Corbett a prisoner at HMP High Down on 22 January 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Corbett died on 22 January 2016, of bronchopneumonia caused from immunosuppression and organ rejection, while a prisoner at HMP High Down. He was 48 years old. I offer my condolences to Mr Corbett's family and friends.

Mr Corbett had had a lung transplant in 2009, and was in poor health when he arrived at High Down in February 2013. His condition continued to decline over time. Overall, I consider that Mr Corbett received good care at High Down, equivalent to that he could have expected to receive in the community. However, there were some communication problems with the hospital responsible for his care, and these might have been avoided by the appointment of a named clinician at the prison to coordinate his primary care. I am concerned that, when Mr Corbett was taken to hospital, the level of restraint used did not reflect his security risk. I have raised this matter before and the Governor needs to make sure that managers authorising restraints understand the legal position and follow Prison Service guidance.

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

August 2016

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Summary

Events

1. On 16 February 2013, Mr John Corbett was remanded to HMP High Down, charged with possession of class A drugs and firearms. In May, he was sentenced to 12 years in prison. Mr Corbett, had had a bilateral lung transplant in 2009, and was in poor health. A doctor prescribed the medication he needed.
2. Transplant consultants and other specialists reviewed Mr Corbett frequently. In July 2013, Mr Corbett's lung function rapidly deteriorated and doctors decided he should be assessed for irradiation therapy. Mr Corbett started the new therapy in January 2014, and doctors stopped his immunosuppressant medication. The prison did not receive a discharge summary until a month after he left hospital. The letter indicated he needed a specialist review to consider when he would need to start taking immunosuppressant medication again. He did not have an appointment until June, which delayed him starting medication again.
3. Over the next year transplant consultants and other specialists continued to see Mr Corbett regularly and his condition steadily deteriorated.
4. By January 2015, Mr Corbett was losing weight and his lung function was poor. He continued to have frequent specialist investigation and treatment throughout 2015. In January 2016, Mr Corbett was admitted to hospital for planned treatment. As with previous appointments, he was restrained. Officers used double handcuffs on the way to hospital and an escort chain during treatment. Mr Corbett became critically ill in hospital and the restraints were removed. He died on 22 January.

Findings

5. We are satisfied that, overall, Mr Corbett received good care at High Down. However, we agree with the clinical reviewer, that a named prison clinician to take responsibility for his care and plan regular reviews, might have allowed better communication with the hospital and avoided some omissions in his care, such as the delay in making an appointment after his irradiation therapy in January 2014.
6. Although Mr Corbett was a category C prisoner and in poor health, double handcuffs were used, without justification, for his journeys to hospital.

Recommendations

- The Head of Healthcare should ensure that all patients with chronic serious illnesses have a lead clinician responsible for their care and a planned programme of reviews.
- The Governor should ensure that managers understand the legal position and follow Prison Service guidance when authorising restraints for prisoners taken to hospital and that risk assessments are based on the actual risk the prisoner presents at the time.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP High Down 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 Corbett's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Corbett's clinical care at the prison.
10. We informed HM Coroner for Surrey of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Corbett's sister, to explain the investigation. She did not have any specific matters for the investigation to consider.
12. Mr Corbett's sister received a copy of the initial report. She pointed out a factual inaccuracy. This report has been amended accordingly.
13. The prison also considered our initial report and raised some factual inaccuracies which have been amended. The prison submitted an action plan.

Background Information

HMP High Down

14. HMP High Down is a local prison near Sutton, in Surrey, which at the time held up to 1,150 men. Virgin Care provides primary health services at the prison, Achor Healthcare the GP services and Central and North West London (NHS Foundation Trust) in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

15. The most recent inspection of High Down was in January 2015. Inspectors reported that health services were good overall, but staff shortage resulted in too many cancelled appointments. Prisoners had prompt access to a range of pharmacy services, which reduced the need for GP appointments, which the inspectorate considered good practice.

Independent Monitoring Board

16. 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 December 2015, the IMB was concerned about the negative effect of low staffing levels, which reduced prisoners time out of their cells and hampered communication between officers and prisoners. Managerial and system changes had led to improved attendance at healthcare appointments.

Previous deaths at HMP High Down

17. Mr Corbett was the sixth prisoner to die of natural causes at High Down since January 2014. We have raised the issue of the unjustified use of restraints before.

Key Events

18. On 16 February 2013, Mr John Corbett was remanded to HMP High Down charged with possessing class A drugs and firearms. At an initial health screen, a healthcare assistant noted that Mr Corbett was in poor health. He had had a bilateral lung transplant in 2009, after suffering sarcoidosis (a condition where cells in the lungs inflame and cause nodules to form) and needed frequent follow-up appointments at the transplant clinic at hospital. Mr Corbett monitored his own lung function, using a peak flow meter. He said he smoked about five cigarettes a day. A GP prescribed Mr Corbett's medication, including antibiotics and immunosuppressants to help prevent rejection of the lung. Mr Corbett was admitted to the prison's healthcare unit for three days for monitoring.
19. On 9 May, Mr Corbett was sentenced to 12 years in prison. Transplant consultants and other specialists at hospital continued to review and monitor Mr Corbett frequently. Over the following months, he had frequent scans, blood, blood pressure and lung function tests. Specialists noted that Mr Corbett's condition was deteriorating and assessed him for total lymphoid irradiation treatment, which is a form of radiotherapy targeted at the lymphoid tissue that produces antibodies. It can replace the need to take immunosuppressant medication.
20. On 2 December, a transplant consultant at hospital reviewed Mr Corbett and noted that his lung function continued to decline and that he needed to be admitted to an appropriate medical facility for the duration of his irradiation treatment. He noted that Mr Corbett should begin the treatment as soon as possible.
21. There was some discussion about whether Mr Corbett could have the treatment at another hospital, which is near High Down, and a consultant at the hospital reviewed Mr Corbett on 4 December. The consultant wrote to his consultant at the previous hospital and noted that this was not a standard procedure at the other hospital and that it was unlikely that they would be able to start the treatment before Christmas.
22. In the event, Mr Corbett had the treatment at the hospital and was admitted on 6 January 2014, for 23 days. The consultant wrote a discharge summary and noted that they would review Mr Corbett two weeks later in an outpatient clinic and would consider when it was appropriate to restart his immunosuppressant medication, which was stopped during the radiation therapy. The letter (as with most of the letters from the consultant) was addressed to Mr Corbett's community GP and the prison do not appear to have received a copy until 28 February. The need for a further appointment was not followed up by either the hospital or the prison and there is nothing in Mr Corbett's medical records to explain this.
23. Eventually, on 9 June, the transplant consultant reviewed Mr Corbett and wrote to the Healthcare Centre at High Down (the only letter we have found from the consultant addressed to the prison) noting that he should have seen Mr Corbett in February and that the prison had not sent any blood count tests, which meant that he had not received the immunosuppressant medication he needed. Mr

Corbett's pulmonary and lung function tests had deteriorated significantly and a recent course of antibiotics for a lower respiratory tract infection had not been fully effective. The consultant prescribed immunosuppressants, antibiotics and medication to clear his respiratory tract of sputum. He arranged to see him again in ten days. On 19 June, Mr Corbett was admitted to hospital for a CT scan, bronchoscopy and biopsy. On 23 June, he was discharged and prison healthcare staff noted that his pulmonary and lung function had improved after treatment. The discharge letter was addressed to his community GP and copied to Mr Corbett.

24. On 12 August, a transplant specialist at the hospital reviewed Mr Corbett. She was concerned about Mr Corbett's reduced lung function and prescribed a nebuliser and medication. On 23 October, a bronchoscopy indicated Mr Corbett had an infection, for which he received treatment.
25. Over the next year, transplant and other specialists saw Mr Corbett frequently. He started to lose weight and his condition began to deteriorate further. He had hospital treatment in October 2015, to remove antibodies from his blood.
26. On 26 November 2015, Mr Corbett was admitted to hospital and a bronchoscopy showed he had bilateral bronchiectasis (where the bronchial tubes are abnormally widened and susceptible to infection) and a possible airway inflammation caused by a hypersensitive immune system response. He received treatment in hospital and was discharged to High Down on 30 November
27. On 11 January 2016, Mr Corbett was admitted to the hospital transplant unit for further planned treatment. As with previous hospital admissions, a prison manager, decided that he should be restrained. Officers used double handcuffs for the journey and an escort chain in hospital.
28. On 13 January, records show that hospital doctors told Mr Corbett his treatment did not seem to be working and his condition was deteriorating. On 16 January, doctors decided to keep Mr Corbett in hospital, as he was in a lot of pain. Over the next few days he had more trouble breathing and suffered pain in his sternum. Hospital staff gave him anti-sickness tablets and pain relief.
29. On 20 January, doctors noted that Mr Corbett had a viral infection and his treatment would have to be postponed until it cleared. Around 7.30pm, Mr Corbett became critically ill and was taken to the hospital's intensive care unit. The duty governor agreed to remove restraints.
30. By 21 January, Mr Corbett was in a coma and on life support. On the afternoon of 22 January, doctors withdrew life support and nurses recorded his death at 3.05pm. His family were with him when he died.

Contact with Mr Corbett's family

31. On 20 January, when his condition became critical, Mr Corbett asked staff to inform his sister and she visited him later that evening. An officer was the prison's family liaison officer and went to the hospital on the morning of 22 January, where he met Mr Corbett's brother and sisters. After Mr Corbett died, he offered his condolences and support.

32. Mr Corbett's funeral was on 22 February 2016. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

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

Cause of death

34. The coroner informed us that the cause of death was bronchopneumonia caused by immunosuppression (reduction of the body's immune system) and chronic organ rejection as a result of lung transplant sarcoidosis.

Findings

Clinical care

35. The clinical reviewer noted that 50% of lung transplant patients can expect to live for five years after surgery and 30% up to ten years. Mr Corbett survived for nearly seven years after his lung transplant. It is clear that he was very unwell and his prognosis was limited despite the treatment and care he received. He is satisfied that Mr Corbett received good care for his condition at High Down and that his care was equivalent to that he could have expected to receive in the community.
36. Mr Corbett missed a follow up appointment after his irradiation treatment in January 2014, which meant doctors did not restart his immunosuppressant medication again until June. The Head of Healthcare at High Down told us that the prison did not receive a discharge summary until the end of February, a month after he had returned from hospital. (We note that most of the consultant's letters from Harefield Hospital were addressed to Mr Corbett's community GP rather than to a member of healthcare staff at High Down.)
37. The Head of Healthcare considered that earlier receipt of the discharge summary would have prompted staff to make the follow up appointment, but acknowledged that they should have chased the hospital for the discharge summary. We are also surprised that the hospital did not follow this up. (Hospital care is outside the remit of this investigation.) We are satisfied that the Head of Healthcare has now changed healthcare procedures so that staff chase missing hospital discharge summaries and follow up any action. We therefore do not make a recommendation about this issue.
38. The clinical reviewer said that Mr Corbett showed a considerable decline in lung function after February 2014, and he was not monitored to check when he should restart his immunosuppressant medication. (There is no record that the hospital asked healthcare staff to monitor Mr Corbett's blood count and it is not mentioned in the January discharge letter.) The clinical reviewer noted that it was not clear whether this decline could be attributed to any delay in starting his medication again, as his decline continued after he started taking immunosuppressant medication in June.
39. The clinical reviewer acknowledged that it can be very difficult to clearly define the boundaries of responsibility between the primary healthcare (prison healthcare), the hospital, and the patient, for a chronic and rare condition. Most chronic conditions have recommended levels of primary monitoring but there are none for Mr Corbett's condition; his care was mostly managed by consultants. However, she said that it would have been usual to have one assigned primary health clinician responsible for the care of someone with a serious medical condition. This might have helped avoid some communication difficulties with the hospital and led to prompter reviews. We make the following recommendation:

The Head of Healthcare should ensure that all patients with chronic serious illnesses have a lead clinician responsible for their care and a planned programme of reviews.

Restraints, security and escorts

40. 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.
41. Mr Corbett attended hospital for appointments and treatment many times. We have not seen all the risk assessments for these appointments, but it is apparent that Mr Corbett was restrained. The level of restraint was unclear, but when Mr Corbett went to hospital for treatment in January 2016, double handcuffs were used for the journey and an escort chain in hospital. An escort chain is a long chain with handcuffs at either end, one attached to an officer and the other to the prisoner. Double handcuffing means that the prisoner's hands are handcuffed in front and one wrist is attached to an officer by an additional set of handcuffs.
42. A nurse completed the medical section of the risk assessment and noted Mr Corbett walked slowly and got short of breath. His condition was life threatening but he was not terminally ill. She did not object to the use of restraints. An administrator in the security department completed the rest of the risk assessment and recommended that staff should use double handcuffs during Mr Corbett's transfer to hospital and an escort chain once he arrived. A prison manager agreed. Restraints were removed on 20 January, when it was recognised that Mr Corbett was critically ill.
43. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Double cuffs are usually used for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner, like Mr Corbett, the Prison Service requires that reasons should be recorded in writing. There was no evidence to support this decision and we cannot see how it could be justified. The prison has not responded to requests to explain the decision. We have raised the issue of the unjustified use of restraints, including the use of double handcuffs, with the prison before. We make the following recommendation:

The Governor should ensure that managers understand the legal position and follow Prison Service guidance when authorising restraints for prisoners taken to hospital and that risk assessments are based on the actual risk the prisoner presents at the time.

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