

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gary Chapman a prisoner at HMP North Sea Camp on 27 February 2017

**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 Gary Chapman died on 27 February 2017 of complications caused by lung cancer, while a prisoner at HMP North Sea Camp. He was 54 years old. I offer my condolences to Mr Chapman's family and friends.

Mr Chapman was diagnosed with a terminal illness after arriving at North Sea Camp, and I consider that the care he received there was of a high standard. However, I believe that HMP Hatfield, to which Mr Chapman hoped to transfer to be nearer his family, ought to have done more to facilitate his move.

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 2017**

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# Summary

## Events

1. On 29 April 2015, Mr Gary Chapman was sentenced to five years and eight months imprisonment for drug offences. He spent time at a number of prisons, before arriving at HMP North Sea Camp in June 2016.
2. Mr Chapman had no medical concerns when he arrived at North Sea Camp, but during the summer he developed respiratory problems. Healthcare staff treated him with antibiotics and a nebuliser, to administer medication in the form of mist inhaled into the lungs, on a number of occasions. He was also taken to hospital several times. On 28 August, he was diagnosed with pneumonia. A prison GP considered referring him for a lung assessment a few days later. On 21 September, Mr Chapman attended a gastroenterology appointment and was referred by the specialist for a CT scan of his chest and abdomen. This was performed on 22 October.
3. On 24 October, Mr Chapman was found barely responsive in his cell and was taken to hospital. Biopsies were taken from his lungs and, on 3 November, Mr Chapman was diagnosed with terminal lung cancer. He had further tests at the end of November to confirm the extent of this cancer and his treatment plan.
4. In early December, Mr Chapman became very ill and was rushed to hospital for an operation to remove part of the tumour in his lung, and to insert an artificial airway to assist his breathing. He began a course of radiotherapy at the end of December to address his cancer but his health continued to decline.
5. On 21 February, Mr Chapman's condition deteriorated rapidly overnight, and he was sent to hospital. He remained there until his death on 27 February.

## Findings

### Mr Chapman's clinical care

6. We agree with the clinical reviewer that Mr Chapman received a level of care at HMP North Sea Camp equivalent to that which he could have expected to receive in the community. Healthcare staff responded quickly to any deterioration in his condition and made appropriate and timely referrals to external specialists, particularly in respect of his cancer diagnosis. After Mr Chapman was diagnosed with a terminal illness, the prison supported him well, both to treat his symptoms and to keep him as comfortable as possible.

### Mr Chapman's location

7. After Mr Chapman's cancer diagnosis, staff at North Sea Camp made significant efforts to facilitate his transfer to HMP Hatfield so he could be closer to his family. On 17 November 2016, a member of healthcare staff at Hatfield stated that Mr Chapman could not transfer because he had already begun treatment for his cancer at North Sea Camp. However, Mr Chapman's treatment was not due to begin until the end of December and we are concerned that Hatfield failed to consider Mr Chapman for this transfer appropriately.

8. Staff at North Sea Camp investigated the possibility of a transfer to a different prison but this was also rejected by the other prison. Mr Chapman was referred to a local hospice and plans were formed to facilitate a move but he died before it could happen. While Mr Chapman was at North Sea Camp he was located appropriately, with consideration given to his medical needs and dignity. We consider that the prison acted appropriately.

### **Compassionate release and release on temporary licence**

9. North Sea Camp supported Mr Chapman in granting temporary licences to allow him to travel unaccompanied to medical appointments. After his cancer diagnosis, the prison agreed his application to extend these licences to enable him to have unaccompanied visits to see his partner. We find that the prison acted appropriately in granting these applications.
10. An application for release on compassionate grounds was initiated by the prison on Mr Chapman's behalf in early December. When he received a prognosis of less than three months' life expectancy in January, staff at the prison submitted this application immediately. Unfortunately, Mr Chapman died before this process could be completed but we are satisfied that the prison acted appropriately in beginning the compassionate release process when they did.

### **Liaison with Mr Chapman's family**

11. The prison supported Mr Chapman with contact with his family throughout his time at North Sea Camp, and we are satisfied that they did so appropriately.

### **Recommendations**

- **The Governor and Head of Healthcare at HMP Hatfield should adhere to the provisions of PSO 3050, *Continuity of Healthcare for Prisoners* when considering requests for transfer.**

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Chapman's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Chapman's clinical care at the prison.
15. We informed HM Coroner for South Lincolnshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. The investigator wrote to Mr Chapman's wife and son to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not respond to our letter.
17. The investigation has assessed the main issues involved in Mr Chapman'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.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## Background Information

### HM North Sea camp

19. North Sea Camp is an open prison near Boston in Lincolnshire. (Open prisons are for the lowest security category of prisoners who can be reasonably trusted not to escape.) The prison holds over 400 sentenced men in six units. Prisoners assessed as suitable are able to work in the community.
20. Nottingham Healthcare NHS Foundation Trust provides primary healthcare services. A senior nurse manager is in charge of primary care and four doctors from a Boston practice provide three GP sessions a week. Healthcare staff are on duty from 7.30am to 6.30pm during the week and until 12.30pm at the weekend.

### HM Inspectorate of Prisons

21. The most recent inspection of North Sea Camp was conducted in July 2014. The inspectorate found that primary care arrangements, including those for prisoners with long-term conditions, were very good, and support and care for the large number of older prisoners were particularly effective. Pharmacy services were good but medicine administration was not sufficiently confidential. There was an excellent range of emotional support and mental health services.

### Independent Monitoring Board

22. 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 annual report for the year to 29 February 2016, the IMB was generally positive about health services at the prison. It noted that at times during the reporting period there had been a shortage of trained nurses due to resignations and the unreliability of agency staff. The prison has since appointed additional permanent staff.
23. The IMB also noted that NHS changes have often resulted in prisoners with complex conditions no longer receiving treatment in local hospitals. This has put a strain on the provision of hospital escorts and some planned appointments at local hospitals have been missed or rearranged. However, no urgent appointments have been missed.

### Previous deaths at HMP North Sea Camp

24. Mr Chapman was the third prisoner to die from natural causes at North Sea Camp since January 2015. There were no similarities between the circumstances of Mr Chapman's death and the previous deaths at the prison.

# Findings

## Mr Chapman's diagnosis and informing him of his condition

25. Mr Gary Chapman was sentenced to five years and eight months imprisonment for drug offences on 29 April. He spent time at a number of prisons, before arriving at HMP North Sea Camp on 29 June 2016.
26. On his arrival at North Sea Camp, a nurse reviewed Mr Chapman at a reception health screen. He had no health concerns at this time.
27. On 25 July, a prison GP saw Mr Chapman after he complained of a cough, a dry mouth and losing his voice a few weeks earlier. The GP prescribed antibiotics and a spray, and advised him to stop smoking. Two weeks later, Mr Chapman complained of being hoarse, short of breath, and having a dry mouth. Healthcare staff treated Mr Chapman with a nebulizer, but sent him to hospital when his condition became worse. Mr Chapman was discharged the same day with a prescription for antibiotics.
28. On 23 August, Mr Chapman saw a worker from the Community Health Service with a pain in his chest. Mr Chapman was given an electrocardiogram (ECG) test, which measured the electrical rhythm of his heart, which was unremarkable. He suspected a chest infection and gave Mr Chapman a portable nebulizer. Mr Chapman did not improve, and five days later he was sent to the hospital where he was diagnosed with pneumonia.
29. On 2 September, a prison GP examined Mr Chapman on 2 September, after he reported as unwell. He planned blood tests, and a further chest X-Ray before the end of the month. He recorded that Mr Chapman might need a referral for a lung assessment.
30. On 7 September, a prison GP reviewed abnormal blood results for Mr Chapman and suspected upper gastrointestinal cancer. He made an urgent referral to the gastroenterology department under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Chapman attended this appointment on 21 September and was referred by the consultant for a CT scan of his chest and abdomen. This scan was performed on 22 October.
31. On 24 October, a nurse saw Mr Chapman after he collapsed in his cell. She noted that Mr Chapman was breathing but barely responsive and had a grey pallor, so she sent him to hospital for a review. While in hospital, Mr Chapman had a bronchoscopy (a diagnostic technique used to examine the airways). On 28 October, a nurse saw Mr Chapman on his return to prison, and observed: "...biopsies have been taken which will take approx 1 week for results". She also noted that a primary diagnosis revealed a number of issues, including a large mediastinal mass which might be malignant. (Mediastinal tumours are benign or cancerous growths that form in the area of the chest that separates the lungs.)
32. On 30 October, Mr Chapman was found unconscious and sent to hospital. He was discharged the same day.

33. On 3 November, Mr Chapman attended hospital for a review of the biopsy test results and was told that he had non-small cell lung cancer. They explained that the hospital needed to identify the extent of the disease by means of a PET scan. (Positron Emission Tomography scans produce detailed three-dimensional images of the inside of the body). The hospital would then establish the appropriate means of treatment and referred Mr Chapman to another hospital for this procedure.
34. We are satisfied that Mr Chapman's diagnosis was appropriately recorded and acted on by the prison.

### **Mr Chapman's clinical care**

35. On 3 November, a nurse met officers involved with Mr Chapman to discuss his diagnosis and the support he would need. She created a care plan for Mr Chapman, which included his pain relief management, weight monitoring and supplementary foods. Mr Chapman's care and condition was reviewed regularly during his time at North Sea Camp.
36. On 8 November, a nurse called the hospital to chase up the PET scan. She was told they had not yet received the referral, so she spoke to staff at another hospital, and they faxed it through again. The scan was scheduled for 17 November, but could not be performed that day because Mr Chapman had consumed a drink. It was subsequently performed on 23 November. By 3 December, Mr Chapman's PET scan results had still not been received, so the nurse noted the need to chase these up the following week.
37. On 24 November, a nurse saw Mr Chapman, who was coughing blood and in a lot of pain. Mr Chapman was sent to hospital and treated with intravenous antibiotics. He was discharged on 29 November.
38. On 4 December, Mr Chapman was sent to hospital because he was struggling to breathe. Two days later, he was transferred to another hospital for urgent surgery on a suspected collapsed lung. The next day, Mr Chapman had surgery to remove as much as possible of the tumour, and had a tracheobronchial stent (a tube-shaped device to aid breathing) inserted into his airway. Mr Chapman was discharged back to North Sea Camp on 12 December. A nurse saw Mr Chapman on his return and explained to him that this operation had shrunk the tumour and decreased the symptoms but would not cure the cancer.
39. On 19 December, Mr Chapman attended hospital to discuss his treatment plan. The oncology consultant referred Mr Chapman to the Medical Assessment Unit after he experienced breathlessness. He was kept in hospital for three days. On 22 December, the Radiotherapy Department called the prison to confirm five radiotherapy appointments for Mr Chapman from the end of December.
40. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided. On 23 December, a nurse saw Mr Chapman on his return from hospital and noted that he had signed a DNACPR form and that this was his intention.

41. On 31 December, a nurse examined Mr Chapman and noted that his observations were abnormal. Mr Chapman was sent to hospital and kept in for observations. Mr Chapman missed a radiology appointment while he was in hospital, because the hospital refused to transport an unaccompanied prisoner. A nurse spoke to staff at the hospital to explain that Mr Chapman did not require an escort. The appointment took place the next day.
42. Mr Chapman voiced suicidal intentions while he was at the hospital and, on 16 January 2017, an ACCT document (Assessment, Care in Custody and Teamwork) was opened for him. This ACCT document was closed the next day at the first ACCT review, when staff accepted that Mr Chapman did not intend these comments to be taken seriously.
43. Mr Chapman was reviewed regularly by healthcare staff during his time at North Sea Camp. On 29 January, Mr Chapman was given a part-time buddy (a prisoner carer) after he asked for help to get around. On 30 January, a nurse became concerned about Mr Chapman's personal hygiene and suggested that healthcare staff could help him to wash in their bathroom. Mr Chapman declined this offer, but agreed to let staff help him to wash his hair in his cell. A week later, a nurse offered Mr Chapman the use of the disabled shower, but again Mr Chapman declined.
44. On 20 February, a nurse saw Mr Chapman on his unit after he reported feeling unwell. She observed that Mr Chapman had numbness in his chest similar to having a dead arm, but that he could raise both arms above his head, had a good grip, and his observations were normal. She advised him to tell staff if he did not improve, and to visit the healthcare unit the next day. Mr Chapman deteriorated overnight, and was taken to hospital.
45. A nurse called the hospital on 27 February, and recorded at 12.10pm that Mr Chapman had appeared to have had a fit, had limited movement and was unable to talk. She called again later and noted at 4.54pm that the hospital thought that Mr Chapman's cancer had invaded his brain.
46. The hospital pronounced Mr Chapman dead at 6.10pm on 27 February.
47. The post-mortem report stated that Mr Chapman died from dissemination intravascular coagulation (blood clotting in the vessels of the lung) caused by lung cancer and a pulmonary embolism (a blockage in the main blood vessel feeding the lungs).
48. We agree with the clinical reviewer that the care Mr Chapman received was of a good standard. He was regularly reviewed by healthcare staff, and care plans were in place to deal with all of his needs. We are satisfied that Mr Chapman's care was equivalent to that he could have expected to receive in the community.

### **Mr Chapman's location**

49. On 3 November, a nurse met other officers and emphasised the need for Mr Chapman to have contact with his family to provide moral support following his cancer diagnosis. She noted that his application for a transfer to HMP Hatfield should be expedited so that he could be closer to home.

50. On 16 November, the nurse recorded that Mr Chapman's transfer to Hatfield had been granted, and telephoned healthcare staff at Hatfield to explain his condition. The next day, she spoke to healthcare at Hatfield, who said they were not able to accept Mr Chapman, citing Prison Service policy that prisoners should not be moved during treatment. She explained that Mr Chapman had not yet begun treatment, because he was waiting for a PET scan, and that he should be closer to his family for support. They said this was not a valid reason to move him. The nurse spoke to a Governor about this. He told her that it was a matter for healthcare departments to sort out between themselves, and advised her to send an email. On 20 November, she emailed a Governor and the healthcare manager covering North Sea Camp. There is no record of a reply. On 16 December, a nurse noted that Mr Chapman's proposed transfer to Hatfield had been declined. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, states:

**a) Clinical Hold**

5.5 *Patients may sometimes need to be placed on 'clinical hold' (i.e. withheld from transfer for a period of time for clinical reasons when indicated). This system will require local audit through clinical governance arrangements to ensure that;*

- *Clinical risk is managed*
- *The operational running of the prison is not adversely affected by excessive numbers of clinical holds*

5.6 ***For instance, it will almost never be appropriate to transfer a patient awaiting urgent cancer referral. Where turnover is high, as in local prisons, it may only be possible to hold those patients with clinically urgent appointments. Training prisons may be able to hold more patients awaiting outpatient appointments.***

5.7 *Patients may sometimes be transferred after having waited a considerable time for hospital treatment. In these circumstances details of the wait should be included in the referral letter from the new establishment to determine whether this may be taken into account at the new hospital. Clinicians should attempt to reach agreement that the waiting time will not be reset when the patient is transferred to a new list.*

51. We accept that North Sea Camp took reasonable steps to facilitate a transfer to Hatfield for Mr Chapman. However, we find that Hatfield did not apply the provisions of Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, appropriately, and did not give proper consideration to a transfer for Mr Chapman. In these circumstances we make the following recommendation:

**The Governor and Head of Healthcare at HMP Hatfield should adhere to the provisions of PSO 3050, *Continuity of Healthcare for Prisoners* when considering requests for transfer.**

52. On 17 January 2017, Mr Chapman told an officer he would like to transfer to HMP Humber, because his son was a serving prisoner there and it would be

easier to see his wife and daughter as well. The next day, a Governor contacted Humber, and also enquired whether Mr Chapman's son would be suitable for 'open conditions', with a view to a possible transfer to North Sea Camp instead. On 6 February, Mr Chapman's transfer to Humber was rejected on the grounds of his ongoing medical treatment and condition. Three days later, the officer informed Mr Chapman that his son could not be considered for a transfer to North Sea Camp until he was due a review for open prison conditions in April.

53. On 6 November, a nurse asked Mr Chapman whether he would like to be referred to a hospice, but he declined at that stage. On 24 November, however, Mr Chapman agreed to a referral and was referred by her following a case review meeting on 16 December. A nurse from the hospice visited Mr Chapman on 1 February, and again a week later, with plans to continue these visits on a weekly basis ahead of any transfer. Unfortunately, Mr Chapman died before a transfer could be arranged.
54. On 23 December, Mr Chapman was moved to a single cell for medical reasons and to prevent the risk of infection, due to his upcoming radiology therapy. Mr Chapman was unhappy about this, so the prison moved him back to his old cell three days later and created a PEEP (Personal Emergency Evacuation Plan).
55. We note the efforts made by North Sea Camp to unite Mr Chapman with his son. We are satisfied that Mr Chapman was appropriately located during his time at the prison.

### **Restraints, security and escorts**

56. When prisoners have to travel outside of the 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.
57. Mr Chapman was in an open prison, and was never subject to restraints, so we make no finding.

### **Release on temporary licence**

58. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The Governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.
59. On 5 October, a Governor supported an application by Mr Chapman for ROTL in respect of medical appointments and emergency treatment. This was granted, and Mr Chapman was allowed to travel unaccompanied on licence to the hospital. On 22 November, Mr Chapman was granted permission to extend this ROTL to include family visits for the purpose of maintaining family ties.
60. We find that the prison acted appropriately in supporting Mr Chapman's ROTL applications, and make no recommendation.

## Compassionate release

61. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000, *Parole Release and Recall*. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, 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 Her Majesty's etc (HMPPS).
62. On 7 December, a Governor noted that an application for compassionate release had been initiated for Mr Chapman. On 19 December, a nurse asked a consultant for a prognosis for Mr Chapman, and was told that his life expectancy could exceed three months if he responded well to radiotherapy.
63. On 18 January, a nurse faxed Mr Chapman's compassionate release forms to his consultant. The consultant returned the completed forms on 23 January, and Mr Chapman signed them the same day. On 9 February, she noted that Mr Chapman's compassionate release forms had been submitted, but they were still waiting for a response.
64. Mr Chapman died before release on compassionate grounds could be granted. We are satisfied that the prison acted appropriately in respect of his application, and make no recommendation.

## Liaison with Mr Chapman's family

65. On 4 November, Mr Chapman applied for two unaccompanied visits each month to see his partner. On 22 November, his ROTL was extended to allow him to do this and to maintain close family contact.
66. On 7 December, a Governor liaised with HMP Humber to arrange for Mr Chapman's son to visit him in hospital. The prison also arranged regular inter-prison phone calls for Mr Chapman so he could speak to his son in Humber.
67. Mr Chapman's son was his designated next of kin. Shortly before Mr Chapman's death, an officer was appointed as his family liaison officer, with another officer as the deputy family liaison officer.
68. At midday on 27 February, the officer contacted the chaplain at Humber to pass on a message to Mr Chapman's son about the deterioration in his father's condition. At 2.10pm, he contacted the Duty Governor at Humber, who agreed to try and arrange for Mr Chapman's son to visit him. Unfortunately, this was not arranged in time. At 6.10pm, an orderly officer noted that Humber was contacted to inform Mr Chapman's son of his father's death.
69. On 3 March, the officer went to see Mr Chapman's son at Humber in person, and spent about an hour and half talking with him.

70. Mr Chapman's funeral was held on 22 March and the prison contributed towards the cost in line with national policy.
71. We are satisfied that the prison acted appropriately with regard to contact with Mr Chapman's family.

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