

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Mark McCulloch a prisoner at HMP Leeds on 19 June 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 Mark McCulloch died of liver cancer in hospital on 19 June 2016 while a prisoner at HMP Leeds. He was 43 years old. I offer my condolences to Mr McCulloch's family and friends.

I am satisfied that Mr McCulloch received a good standard of clinical care at Leeds, the equivalent to that which he could have expected to receive in the community, although there was an administrative delay in referring Mr McCulloch under the NHS pathway for suspected cancer.

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**

**January 2017**

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# Summary

## Events

1. On 25 June 2015, Mr Mark McCulloch was remanded into custody and sent to HMP Leeds. On 23 July, he was sentenced to two years in prison for burglary and the possession of an offensive weapon. On arrival, he told healthcare staff he did not have any health concerns.
2. On 1 April 2016, Mr McCulloch complained about fatty lumps in his abdomen that had been present for two to three years. A prison GP told Mr McCulloch to monitor the lumps for any changes to their size or appearance before a doctor would review him.
3. On 19 May, Mr McCulloch told a nurse that he was suffering from abdominal pain. She gave him pain relief and notified a prison GP.
4. A prison GP saw Mr McCulloch on 20 May and noted that the lumps had grown in size with nodules now present. The GP made an urgent referral to the hepatology clinic under the NHS pathway which requires a specialist to see patients with suspected cancer within two weeks. The hospital did not receive the correct referral until 1 June, as the initial prison referral contained the wrong information.
5. On 2 June, Mr McCulloch complained of increasing pain and a prison GP sent him to hospital. Hospital staff diagnosed Mr McCulloch, on 8 June, with liver cancer that had spread to the abdomen and lungs. Hospital staff gave him a prognosis of only weeks to live.
6. Mr McCulloch's condition continued to deteriorate and he died in hospital on 19 June.

## Findings

7. The clinical reviewer found that Mr McCulloch received a good standard of care at HMP Leeds. We agree and commend the caring approach of staff at the prison. While Mr McCulloch was in hospital, there was good communication between the prison and hospital staff. However, there was an administrative delay in referring Mr McCulloch under the NHS pathway, which requires a specialist to see patients with suspected cancer within two weeks. While this delay did not alter the outcome for Mr McCulloch, whose cancer was advanced, it is important that healthcare staff follow national guidelines for referrals for suspected cancer.
8. We are also not satisfied that the prison appointed a family liaison officer quickly enough, after Mr McCulloch received his terminal diagnosis.

## Recommendations

- The Head of Healthcare should ensure that all urgent referrals contain accurate information and are sent within 24 hours.

- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr McCulloch's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr McCulloch's clinical care at the prison.
12. We informed HM Coroner for West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr McCulloch's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
14. The investigation has assessed the main issues involved in Mr McCulloch'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.

# Background Information

## HMP Leeds

15. HMP Leeds is a local prison, which holds up to 1,212 men. On 1 April 2016, Care UK took over the primary healthcare services from Leeds Community Health. Leeds has an inpatient facility with 24 hour nursing care.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Leeds was in December 2015. Inspectors noted that health provision had declined since the last inspection but outcomes for prisoners remained reasonable overall. Waiting times for most clinics were acceptable and chronic disease management arrangements were impressive.

## 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 December 2015, the IMB reported concerns at major changes to staffing levels and management structures. However, staff continued to show high levels of care and respect to prisoners. Overall, healthcare provision had improved over the last 12 months although there were concerns that these standards could deteriorate if staffing levels were affected by Care UK's takeover in April.

## Previous deaths at HMP Leeds

18. Mr McCulloch was the fourth prisoner to die of natural causes at HMP Leeds since January 2015.

# Findings

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

19. On 25 June 2015, Mr McCulloch was remanded into the custody of HMP Leeds. On 23 July, he was sentenced to two years in prison for burglary and possession of an offensive weapon. He had a number of existing health problems when he arrived, including asthma and hepatitis C. However, he did not express any concerns about his health when he arrived at Leeds or until April 2016.
20. On 1 April 2016, a prison GP saw Mr McCulloch after he complained of lumps in his abdomen. He said they had been present for the past two to three years but he had not mentioned them before. He said that he was concerned that they were cancerous because another prisoner had been diagnosed with cancer with similar symptoms. The GP examined his abdomen, noted the appearance of lipomas (a non-cancerous tumour of fatty tissue) and told him to monitor their size and for the appearance of new lumps.
21. A nurse saw Mr McCulloch on 19 May, after he complained of abdominal pain. She prescribed him pain relief and booked a blood test for Mr McCulloch. She noted that once his blood results were available staff should inform a GP.
22. A prison GP saw Mr McCulloch on 20 May. He noted that Mr McCulloch's blood test results were normal, though his abdominal lumps had grown and his abdomen had swollen. He made an urgent referral to the hepatology clinic under the NHS pathway, which requires a specialist to see patients with suspected cancer within two weeks. He requested staff send an immediate two-week referral on 23 May but staff entered the wrong information and the hospital rejected the referral. An administrative assistant heard about this rejection on 25 May and asked a doctor to complete a new urgent referral form. Another GP completed the form on 31 May. Staff sent the second referral on 1 June and the hospital arranged an appointment for 7 June.
23. Mr McCulloch complained to wing staff, on 30 May, that the lumps were still growing and were painful. He said he was taking the pain relief he had been prescribed but he was still in pain.
24. On 31 May, a prison GP saw Mr McCulloch. He noted that Mr McCulloch was complaining that the lumps in his stomach were bigger, painful and that the pain relief was not effective. He set an urgent task for administrative staff to follow up the referral and told Mr McCulloch that he could not rule out cancer at this stage.
25. Mr McCulloch complained of increasing pain, again, on 2 June. A prison GP gave Mr McCulloch pain relief, noted his physical deterioration and arranged for him to go to hospital as an emergency. The hospital admitted him.
26. On 8 June, after a series of tests, hospital staff informed Mr McCulloch that he had cancer of the liver, which had spread to the lungs. Doctors told Mr McCulloch that he only had months to live.

27. The clinical reviewer concluded that Mr McCulloch's medical records show that he received compassionate and responsive care at Leeds, equivalent to the care he could have expected to receive in the community. While the clinical reviewer noted that the delay in referral was unlikely to have impacted upon the outcome for Mr McCulloch, it is important that urgent referrals are dealt with quickly and accurately. We make the following recommendation:

**The Head of Healthcare should ensure that all urgent referrals contain accurate information and are sent within 24 hours.**

#### Mr McCulloch's clinical care

28. On 10 June, a prison GP visited Mr McCulloch in hospital and noted he had been diagnosed with hepatocellular carcinoma (liver cancer) and that his prognosis would now be measured in weeks rather than months.
29. Mr McCulloch's condition did not improve sufficiently for him to return to Leeds and the hospital gave him end of life care. After further deterioration, Mr McCulloch died at 3.00am on 19 June.
30. After hospital doctors diagnosed Mr McCulloch with terminal cancer, the hospital provided his end of life care, which is outside the remit of this investigation.

#### Mr McCulloch's location

31. Mr McCulloch was located in a shared cell prior to his transfer to hospital, where he remained until his death. We are satisfied that Mr McCulloch was appropriately accommodated while at Leeds.

#### 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. For Mr McCulloch's admission to hospital, on 2 June, healthcare staff indicated (by ticking a yes/no answer) that there were no objections to restraints, no other medical considerations and the treatment could not take place in the prison. In the risk assessment, a security officer stated that Mr McCulloch presented a low risk to the public and of escape. Using this information, a prison manager authorised for two officers to escort Mr McCulloch and restrain him using a single set of handcuffs.
34. After hospital staff admitted Mr McCulloch to hospital, a prison manager reviewed the risk assessment. He decided to decrease the level of restraint to an escort

chain while Mr McCulloch remained in hospital. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.

35. On 10 June, a prison manager consulted with a prison GP and noted that removing the handcuffs would be the appropriate and decent thing to do. Mr McCulloch remained uncuffed until his death.
36. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account, and balanced against the security risks. We are satisfied that the prison made an appropriate decision to restrain Mr McCulloch's until 10 June because his health and mobility had not deteriorated significantly at that point. After Mr McCulloch received his terminal diagnosis, we are satisfied that prison managers reviewed the level of restraint used and took into consideration how his health and mobility had diminished, which affected his risk of escape.

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

37. HMP Leeds appointed a prison manager as the family liaison officer. On 16 June, she contacted Mr McCulloch's sister and introduced herself. Mr McCulloch's sister informed her that his family members were aware of Mr McCulloch's diagnosis.
38. On 19 June, approximately an hour after Mr McCulloch's death, the Duty Governor visited the hospital to offer her condolences and support to Mr McCulloch's family. On 20 June, the prison manager sent a condolences card to Mr McCulloch's sister before speaking to her on 21 June.
39. Mr McCulloch's funeral was on 12 July. The family arranged the funeral and the prison contributed to the cost, in line with national instructions.
40. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, Prison Service Instruction (PSI) 64/2011, about safer custody, states that where prisoners suffer a rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner and engaging with their next of kin.
41. On 8 June, Mr McCulloch was diagnosed with terminal cancer. We would have expected the prison to have appointed someone to support Mr McCulloch and his family from at least the time of his diagnosis. There was no record that anyone formally supported him or his family before 16 June. We make the following recommendation:

**The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.**

## Compassionate release

42. 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.
43. The prison discussed an application for release on compassionate grounds for Mr McCulloch on 16 June but he died before it was completed. As Mr McCulloch died more quickly than expected, we are satisfied that the prison appropriately considered the possibility of compassionate release.

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