Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Harman a prisoner at HMP Elmley on 30 June 2017

A report by the Prisons and Probation Ombudsman

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Kenneth Harman died on 30 June 2017 of oesophageal cancer while a prisoner at HMP Elmley. He was 63 years old. We offer our condolences to Mr Harman's family and friends.

Mr Harman received a good standard of clinical care at Elmley. All of his palliative care needs were met, his next of kin was informed in a timely manner and compassionate release was considered appropriately. However, we are concerned that the prison, avoidably, failed to make the appropriate arrangements for Mr Harman to attend an important hospital appointment.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

Contents

Summary

Events

1. Mr Kenneth Harman was serving four years in prison for threats to kill and had been at HMP Elmley since 15 December 2014.

2. He had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), abdominal hernias, and acid reflux.

3. On 20 February 2017 he complained that when he ate, he had a burning sensation in his throat and had difficulty swallowing.

4. During an appointment with a prison GP two days later, Mr Harman did not mention his swallowing difficulties. The GP noted that he had lost weight, and Mr Harman denied having any symptoms associated with weight loss. The GP prescribed sodium alginate (antacid) and complan (a nutritional meal supplement) and asked Mr Harman to return in two weeks.

5. On 9 March, Mr Harman told a prison GP locum that he was concerned about a lump in his throat, and he had to drink a lot to swallow food. The GP noted he was still losing weight, felt tired and exhausted. He made an urgent referral to gastroenterology under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

6. Mr Harman had an appointment with a hospital specialist on 7 April, who referred him for a gastroscopy (a procedure to look inside the oesophagus, stomach and small intestine) and a CT (computed tomography) scan to take place on 20 April. Mr Harman was unable to attend the appointment because the orderly officer did not arrange a taxi in time to take him to the hospital. A prison GP managed to book a new appointment for a gastroscopy on 8 May, which identified a cancerous growth in his oesophagus.

7. On 15 May, a further CT scan identified that the cancer had spread to Mr Harman's liver and lymph nodes. On 22 June an oncologist told him that although he could potentially receive radiotherapy or chemotherapy, his condition was terminal.

8. A prison GP treated Mr Harman for a chest infection on 19 June, and on 27 June he was admitted to Medway Maritime Hospital. In hospital, he deteriorated and died at approximately 11.00pm on 30 June.

Findings

9. We are satisfied that prison GPs appropriately referred Mr Harman for specialist investigation so there was no delay in his diagnosis and treatment. Once diagnosed, healthcare staff provided palliative care with a holistic approach, and started the process of compassionate release at the earliest opportunity. The care Mr Harman received at Elmley overall, was equivalent to that which he could have expected to receive in the community.

10. However, Mr Harman missed a critical hospital appointment on 7 April which had to be rearranged. Although, the clinical reviewer considered that this delay would not have affected the outcome for Mr Harman, it was avoidable.

11. We would have expected Elmley to appoint a family liaison officer when Mr Harman was taken to hospital, in line with PSI 64/2011.

Recommendations

- **The Governor should ensure that there are appropriate arrangements in place to ensure that prisoners do not miss hospital appointments**.
- **The Governor should ensure that a family liaison officer or appropriate member of staff is appointed when a prisoner is taken to hospital with a serious illness, in line with Prison Service Instructions.**

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

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

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

15. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the cause of death. We sent the coroner a copy of this report.

16. The investigator contacted Mr Harman's friend, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any specific issues he wanted considered.

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

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Elmley

19. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported an identified lead for older prisoners and the health care support offered to these men was consistent and of good quality. Social care arrangements were good. The healthcare team adopted a pragmatic but effective approach to chronic disease management. Complex cases were led by a GP or specialist nurse with multidisciplinary oversight.

Independent Monitoring Board

21. 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 October 2016, the IMB reported that the outpatients department continued to run efficiently with a very caring team that monitored and cared for a wide variety of chronically ill prisoners. Non-attendance was still a major problem, but this had been addressed and was improving with new systems in place.

Previous deaths at HMP Elmley

22. Mr Harman was the seventh prisoner to die from natural causes at Elmley since January 2017. There have been two deaths since. There were no similarities between the circumstances of Mr Harman's death and previous deaths at the prison.

Findings

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

23. Mr Kenneth Harman was serving four years in prison for threats to kill and had been at HMP Elmley since 15 December 2014.

24. He had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and abdominal hernias. In November 2016, on the advice of a respiratory consultant, a prison GP prescribed Mr Harman lansaprole for acid reflux.

25. There are no other relevant entries in Mr Harman's medical record until 20 February 2017 when he told a nurse that he had a burning sensation in his throat when he ate and had trouble swallowing. The nurse told Mr Harman to make an appointment with a prison GP.

26. A prison GP examined Mr Harman on 22 February. Mr Harman did not tell him about his problem swallowing and discussed problems with his ear and indigestion. The GP examined Mr Harman and noted he had lost two kilograms since July 2016 (55kg). Mr Harman denied having vomited, having changes in bowel movements or blood in his stool. The GP prescribed sodium alginate (antacid) and complan (a nutritional meal supplement) and asked Mr Harman to return in two weeks.

27. A prison GP locum examined Mr Harman on 9 March. Mr Harman told the GP that he was concerned about a lump in his throat and had to drink a lot of water to swallow food. The GP noted he was losing weight (53.4kg), and felt tired and exhausted. The GP referred him urgently to gastroenterology under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. He also arranged for urgent blood tests (the results of which did not suggest anything unusual).

28. On 7 April, a hospital specialist referred Mr Harman for a gastroscopy (a procedure to look inside the oesophagus, stomach and first part of the small intestine) and a CT scan on 20 April. This appointment did not happen because the orderly officer did not call a taxi in time. A prison GP booked a new appointment for 8 May.

29. On 8 May, Mr Harman attended his gastroscopy appointment, and was told that he had a cancerous growth in his oesophagus. A nurse discussed this with him when he returned from hospital, as did a GP the next day.

30. The clinical reviewer considered that the care Mr Harman received was equivalent to that which he could have expected to receive in the community. He concluded that Mr Harman showed few early symptoms and there was no delay in referring him to hospital. But for the delayed appointment, he was diagnosed at the earliest opportunity. The clinical reviewer made recommendations which are not relevant to Mr Harman's death but which the Head of Healthcare will need to address.

31. We are concerned that Mr Harman missed a critical hospital appointment on 7 April because the prison failed to make the necessary arrangements. While we understand the challenges involved in the day to day administration at Elmley, this caused unnecessary delay, may have caused distress for Mr Harman, and created avoidable inconvenience for the hospital with significant financial implications. Although the delay would not have affected the outcome for Mr Harman, it could have been critical in other cases. We make the following recommendation:

The Governor should ensure that there are appropriate arrangements in place to ensure that prisoners do not miss hospital appointments.

Mr Harman's clinical care

32. During the days following his diagnosis, Mr Harman was offered mental health support, which he declined, and a palliative care link nurse introduced herself to him.

33. On 25 May, the prison received the results of Mr Harman's CT scan of 15 May which confirmed that his cancer had spread to his liver and lymph nodes. The prison had already ordered more comfortable chairs for him and referred him for assessment of his personal care needs. The next day, a prison GP began managing his pain relief and created a new diet plan.

34. On 9 June, a hospital specialist explained to Mr Harman that he had been referred to the oncology department for radiotherapy or chemotherapy, and that he would have an oesophageal stent inserted to help him swallow. A nurse saw him when he returned but she did not note whether they discussed his oncology referral.

35. A prison GP diagnosed Mr Harman with a chest infection on 19 June as he had complained of being short of breath. The next day, Mr Harman had his stent inserted at hospital. He received further treatment for his chest infection and was discharged the next day.

36. On 22 June, an oncologist told Mr Harman that he could have chemotherapy or radiotherapy, but that he could not be cured. A prison GP discussed this with Mr Harman when he returned. The next day, he said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

37. Mr Harman complained of being short of breath on 24 June, but refused to go to the inpatient unit. He complained again of being short of breath on 27 June and was taken to Medway Maritime Hospital.

38. His condition deteriorated in hospital and he died at approximately 11.00pm on 30 June. The post-mortem examination concluded that Mr Harman died of oesophageal cancer which had spread.

39. Although he missed a potentially critical hospital appointment, we are satisfied that overall, Mr Harman received a good standard of healthcare at Elmley, equivalent to that which he could have expected to receive in the community, particularly during his last few weeks. The clinical reviewer concluded that Mr

Harman received appropriate palliative care, including optimal pain relief and nutrition.

Mr Harman's location

40. Mr Harman had a ground floor double cell in the unit for vulnerable prisoners. As he became increasingly frail and weak, he was encouraged several times to consider moving to the inpatient unit. Mr Harman said he was happy in his cell and signed disclaimers refusing to move, apart from a few hours on 19 June. We are satisfied that Mr Harman was appropriately located throughout his time at Elmley.

Restraints, security and escorts

41. 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.

42. Mr Harman's escape potential was assessed as low in all escort risk assessments. However, due to a previous sexual offence, recent intelligence suggested that he still posed a risk to children. Initially, he was restrained with single cuffs but as his condition deteriorated, he attended hospital without restraints. We are satisfied that Mr Harman was appropriately restrained.

Liaison with Mr Harman's family

43. PSI 64/2011 says that prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin, or a nominated person, of prisoners who are either terminally or seriously ill. Mr Harman's nominated next of kin was a friend. The prison Salvation Army worker contacted him at the end of May, and again on 29 June. He was with Mr Harman on the afternoon of 30 June, the day he died.

44. The prison appointed a family liaison officer the next day. She contacted Mr Harman's friend and offered her condolences. Mr Harman's funeral was held on 7 August. The prison contributed to the costs of the funeral in line with national policy.

45. We would have expected the prison to appoint a family liaison officer on 27 June when Mr Harman was admitted to hospital and engage with the next of kin. We make the following recommendation:

    The Governor should ensure that a family liaison officer or appropriate member of staff is appointed when a prisoner is taken to hospital with a serious illness, in line with Prison Service Instructions.

Compassionate release

46. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a

terminal illness and a poor life expectancy of less than three months. However, if a prisoner is particularly unwell, an application may be submitted even if a prisoner has a longer prognosis.

47. Although an oncologist gave Mr Harman a prognosis of 12 months on 22 June, on 20 June, when his health deteriorated, a senior prison manager started the process of compassionate release. Mr Harman died before the application was completed.

48. The clinical reviewer considered that the 12 month prognosis provided by hospital specialists was optimistic. We agree with the clinical reviewer that for the purposes of compassionate release, prison healthcare should discuss realistic prognoses with hospital specialists at the earliest opportunity. However, in these circumstances, we are satisfied that the prison appropriately prioritised Mr Harman's compassionate release application.

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