Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Harmond a prisoner at HMP Whatton on 30 July 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 Paul Harmond died on 30 July 2017 of lung cancer at HMP Whatton. He was 63 years old. We offer our condolences to Mr Harmond's family and friends.

Although there was a delay in Mr Harmond's cancer diagnosis as doctors at Whatton attributed his chest pain to pre-existing conditions, the clinical reviewer found the doctors' actions were reasonable and that Mr Harmond's care was equivalent to the care he could have expected to receive in the community.

After his diagnosis, the clinical care provided to Mr Harmond was largely good, but there were occasions when he was in severe pain and without access to pain relief. His clinical care in this respect was not equivalent.

There were delays in submitting Mr Harmond's application for compassionate release. We have raised this issue with Whatton previously.

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**

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Summary

Events

1. Mr Paul Harmond had been in prison custody since September 2006 and at HMP Whatton since 28 January 2010. He had smoked since he was 16 and was diagnosed with Chronic Obstructive Pulmonary Disease (COPD - a group of lung conditions that cause breathing difficulties) in January 2013.

2. On 17 January 2017, Mr Harmond was seen by a prison doctor after complaining of a swollen, painful chest muscle. The doctor diagnosed bilateral gynaecomastia, the swelling of the breast tissue caused by hormone imbalance, obesity and older age, and gave Mr Harmond ibuprofen. Mr Harmond was still suffering with pain on 28 March and the doctor gave him an antacid for suspected acid reflux.

3. On 18 April, Mr Harmond was taken to hospital after complaining of chest pain and after various tests, he was diagnosed with terminal lung cancer. Mr Harmond started radiochemotherapy on 20 June in order to try to control the growth of the tumour. However, on 25 June he was told that his cancer had spread and his treatment was stopped. Palliative radiotherapy was given as a hospital inpatient to help manage his pain. Prison staff started an application for compassionate release on 28 June. Mr Harmond returned to Whatton on 6 July.

4. Mr Harmond was moved to The Retreat, the prison's palliative care suite, on 27 July and he died on 30 July. A prison doctor confirmed his death and recorded that he had died from lung cancer. There was no post-mortem.

Findings

5. There was a delay in Mr Harmond's cancer diagnosis because prison GPs did not refer him for an urgent chest X-ray when he presented with chest pain. The prison GPs attributed Mr Harmond's symptoms to his pre-existing conditions. The clinical reviewer considered that GPs in the community may have drawn the same conclusions and therefore concluded that Mr Harmond's care was equivalent to the care he could have expected to receive in the community.

6. After Mr Harmond's diagnosis, his clinical care at Whatton was largely good. However, on at least two occasions he was left in severe pain because he did not have access to pain relief. This aspect of his clinical care was not equivalent to the care he could have expected to receive in the community.

7. Mr Harmond's application for release on compassionate grounds was delayed as the healthcare department took 22 days to complete and return the form. Required paperwork was also missing. Mr Harmond died before his application could be considered.

Recommendations

- The Head of Healthcare should review the management and access to pain relief pathways for prisoners, particularly for those in an end stage terminal illness.

- The Governor and Head of Healthcare at HMP Whatton should ensure that applications for early release on compassionate grounds are progressed without delay.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact her. No one responded

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

10. NHS England commissioned a clinical reviewer to review Mr Harmond's clinical care at the prison. The North Midlands Medical Director also reviewed the care given.

11. We informed HM Coroner for Nottinghamshire of the investigation. Mr Harmond died in the prison's palliative care suite and the Coroner accepted the cause of death given by the prison GP. A post-mortem was not carried out. We have sent the coroner a copy of this report.

12. The investigation has assessed the main issues involved in Mr Harmond'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.

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

Background Information

HM Whatton

14. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences. MITIE Care and Custody Health took over the provision healthcare services from Nottinghamshire Healthcare Foundation Trust on 1 April 2017. The healthcare centre is open from 7.30am to 6.30pm Monday to Friday and from 8.00am to 1.30pm on weekends and bank holidays. There is an out-of-hours service at other times. There are no inpatient beds, but there is a palliative care suite in the healthcare centre for end of life care.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Whatton was in August 2016. Inspectors reported that the quality of health and social care was good, and waiting times for treatment were reasonable. Inspectors found that a mix of appropriately skilled staff in well-integrated teams provided health services, and that they were polite and professional to their patients. The inspectors described the palliative care unit as excellent.

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. The IMB reported that for the first ten months of the reporting year to 31 May 2017, healthcare was provided by Nottinghamshire Healthcare NHS Foundation Trust. From 1 April 2017 the contract for healthcare services went to a private outsourcing company, MITIE.

17. While the Board was pleased with healthcare provision by Nottinghamshire Healthcare NHS Foundation Trust, the Board was extremely concerned about the provision of care to the prisoners since being taken over my MITIE, particularly regarding pharmacy provision with prisoners' prescriptions being delivered late or not at all.

Previous deaths at HMP Whatton

18. Mr Harmond is the seventh person to die from natural causes at Whatton since 2016, the second to die from lung cancer. We have raised the issue of delays in processing compassionate release applications before.

Findings

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

19. Mr Paul Harmond was remanded into custody for sexual offences on 6 September 2006. He was convicted on 14 December, and later given an indeterminate sentence for public protection with a minimum tariff of 34 months.

20. Mr Harmond was transferred to HMP Whatton on 28 January 2010. During an initial health screening the same day, the nurse noted that he had arthritis in both hips but was otherwise fit and well. Mr Harmond told the nurse that he had smoked since he was 16 years old.

21. In January 2013, Mr Harmond was diagnosed with Chronic Obstructive Pulmonary Disease (COPD - a group of lung conditions that cause breathing difficulties), which was managed using Ventolin asthma inhalers. Mr Harmond gave up smoking six months later. In May 2014, Mr Harmond started to smoke again and refused help to stop.

22. On 25 November 2016, Mr Harmond saw a nurse for a COPD annual review. He said that he had given up smoking again after having a number of COPD exacerbations that year. Mr Harmond's breathing on the MRC breathlessness scale was measured at 2, this being defined as 'being short of breath when hurrying on a level or walking up a slight incline'.

23. Mr Harmond saw a doctor on 17 January 2017, after complaining of a swollen left chest which was painful to touch. The doctor diagnosed bilateral gynaecomastia, the swelling of the breast tissue caused by hormone imbalance, obesity and older age. The doctor gave Mr Harmond ibuprofen gel for his chest. The gel was changed to ibruprofen tablets on 8 February when the gel had minimal effect.

24. On 26 February, Mr Harmond complained of shoulder pain. He said that he had not been taking his pain relief regularly. A nurse told Mr Harmond he should continue to take his pain relief and she would review if necessary.

25. Mr Harmond still had pectoral pain and on 28 March he went to see a doctor. He now also complained of a burning pain retrosternally (behind his breastbone), this being worse at night and sometimes after meals. He was not short of breath and had no increase in symptoms on exertion. On examination the doctor could not find anything of concern. He prescribed omeprazole (an antacid) for suspected gastro-oesophageal reflux disease (GORD).

26. At 8.50am, on Tuesday 18 April, a nurse visited Mr Harmond in his cell. He complained of central left chest pain that was radiating through to his back and left arm. The pain had started on the previous Friday and had been ongoing over the weekend. The pain was worse on exertion and eased slightly with rest. He was given aspirin and two puffs of a GTN spray (used to treat possible angina), and taken to Grantham and District Hospital. An electrocardiogram (ECG – a test to check the heart's rhythm) performed by paramedics showed no obvious abnormalities.

27. A chest X-ray completed in hospital showed a shadow on the lung. Mr Harmond was told that he needed a computerised tomograghy (CT) scan (a scan that provides detailed images of the inside of the body) and a respiratory team review. Mr Harmond was returned to Whatton overnight at his own request and returned to hospital the following day, 19 April.

28. A CT scan showed an eight centimetre mass in the apical region (top) of the left lung with erosion of the adjacent rib and enlargement of the regional lymph nodes. A hospital consultant discussed the CT results with Mr Harmond and made an urgent referral under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. Oramorph (a strong painkiller) was given, to be used with paracetamol and codeine when required.

29. Mr Harmond attended Grantham and District Hospital on 24 April for an ultrasound guided biopsy of the lung mass. He spent two days in hospital. The results of the biopsy showed squamous cell cancer of the lung. He returned to prison on 26 April with codeine and Oramorph to manage his pain.

30. There was a delay in Mr Harmond's cancer diagnosis. According to National Institute for Care and Health Excellence (NICE) guidelines, Mr Harmond should have been referred for an urgent chest X-ray when he presented with chest pain, because he was aged over 40 and was a former smoker. Prison GPs did not make the referral because they attributed Mr Harmond's symptoms to his pre-existing conditions, namely his COPD and gynaecomastia. The clinical reviewer considered that GPs in the community may have drawn the same conclusions and therefore Mr Harmond's care was equivalent to the care he could have expected to receive in the community.

Mr Harmond's clinical care

31. A hospital Macmillan nurse spoke to Mr Harmond to discuss treatment options before he was discharged back to Whatton on 26 April. He agreed to have radiochemotherapy.

32. A doctor met Mr Harmond the following day to discuss his diagnosis. He was not in pain and felt positive about his treatment plan. He did however complain of shortness of breath when walking so she asked for a wheelchair to be arranged.

33. On 11 May, a doctor saw Mr Harmond when he complained of increased pain. She prescribed Zomorph in addition to the Oramorph he already took. A nurse arranged for Mr Harmond to have a Positron Emission Tomography (PET) scan (a scan that shows how body tissues are working and what they look like) and a magnetic resonance imaging (MRI) scan (a scan that produces detailed images of the inside of the body) at City Hospital, Nottingham. This was initially delayed as on 15 May, Mr Harmond signed a medical disclaimer refusing to attend his appointment but he later agreed to attend.

34. Mr Harmond saw a hospital consultant on 25 May, as part of a multidisciplinary review. The consultant told Mr Harmond that his PET and MRI scans confirmed that there was no evidence that his cancer had spread any further and that he should have a life expectancy of at least six to 12 months.

35. On 26 May, Mr Harmond saw a doctor to discuss his recent hospital visit. He told the doctor that he was in pain and that he did not have any Oramorph. It is unclear how long he had been without it. Mr Harmond's medical records show the reason as listed as "supply by pharmacy". The doctor increased his prescription of Zomorph from 10 to 20mg and asked a nurse to chase up his Oramorph prescription with the pharmacy.

36. On 6 June, a nurse saw Mr Harmond for a cancer care review. He was struggling to sleep due to shoulder and back pain and was now short of breath after walking more than 20 yards. He had noticed a decline in his mobility in recent weeks but wanted to remain as independent as possible. He used a wheelchair to attend healthcare. Mr Harmond now had help to clean his cell, and help to carry his meals back to his cell if needed. A doctor increased Mr Harmond's Zomorph to 30mg later that day after his complaints of increased pain. She also prescribed nutritional high calorie drinks.

37. The consultant oncologist at Nottingham University Hospital reviewed Mr Harmond on 15 June. He explained that they planned to try to shrink and control the growth of the tumour with chemotherapy and radiotherapy. Mr Harmond started his treatment (as an outpatient) on 20 June.

38. Mr Harmond complained of severe chest pain and pain under his arm on 25 June. Mr Harmond was taken to Grantham and District Hospital Accident and Emergency department for assessment. He was later admitted to hospital and reviewed by the Respiratory Lung Multi-Disciplinary team where he was told that his tumour had grown further into his ribs. It was decided that it was not in his best interest to continue with his radiochemotherapy as his cancer was now too advanced. The focus would now be on managing his symptoms and making him comfortable. Mr Harmond remained an inpatient while receiving palliative radiotherapy.

39. Mr Harmond returned to Whatton on 6 July. He moved to A wing where a wing carer was available. A palliative care plan was created asking healthcare staff to review his pain relief regularly and to support Mr Harmond with his daily activities and provide emotional support.

40. On 17 July, Mr Harmond complained of spinal pain with shooting pains down his legs and increased breathlessness. He was reviewed by a doctor who suspected the pain was due to degeneration of his spine as the tumour progressed. They discussed his prognosis and a move to The Retreat (palliative care suite) when required. Mr Harmond said he felt well cared for on the wing but was fearful of the progression of his illness and admitted to having panic attacks at the thought of this. Diazepam was prescribed to help with his anxiety. Mr Harmond discussed his end of life wishes and told Dr Stewart that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. He had run out of Oramorph and the doctor ordered some more for him. It is again unclear how long he had been without his Oramorph and if the pharmacy had insufficient supplies or if his prescription had not been enough.

41. Mr Harmond's condition continued to deteriorate and he became bed bound. A night time carer was employed on 24 July to help Mr Harmond during 'out of hours'.

42. He was moved to The Retreat on 27 July to receive full time one on one care. A syringe driver was introduced the same day to administer continuous pain relief. End of life wishes were discussed again on 29 July, and Mr Harmond confirmed that he did not want to be resuscitated. Mr Harmond was now on the Gold Standards Framework (GSF - a model of good practice that enables a high standard of care for all people who are nearing the end of their lives) as he was expected to live only a few more days.

43. At 4.10am on 30 July, the night carer told prison staff that Mr Harmond appeared to have taken his last breath. At 7.52am, an out of hours doctor attended the prison and confirmed that Mr Harmond had died.

44. Mr Harmond had regular ongoing cancer care reviews to review his comfort, daily living activities, mobility, skin integrity and pain relief, which was good practice. However, he did not always have access to his pain relief medication, which resulted in him being in severe pain. When the syringe driver was set up in The Retreat there were also reported problems with this not working initially.

45. We agree with the clinical reviewer that the healthcare provided to Mr Harmond after his diagnosis was largely equivalent to the care he could have expected to receive in the community, apart from the management and supply of his pain relief medication.

    We make the following recommendation:

    The Head of Healthcare should review the management and access to pain relief pathways for prisoners, particularly for those in an end stage terminal illness.

Mr Harmond's location

46. Staff at Grantham and District Hospital completed a social care assessment on 6 July 2017 after Mr Harmond had been an inpatient for 11 days. He did not need extra support due to his pain being managed enabling him to remain independent. Mr Harmond was later moved to a larger cell and provided with a hospital profiling bed, a walking frame and a shower chair.

47. On 23 July, an open door policy was agreed and a wrist alarm was given after he fell out of bed during the night. Healthcare staff arranged for a night time carer to start the following day.

48. On 27 July, after Mr Harmond's condition deteriorated, he was moved to The Retreat, the prison's end of life care suite. Appropriate equipment was provided to allow him to remain as independent as possible. Once he moved to The Retreat, nursing care was provided under hospice conditions. We consider Mr Harmond's location after his diagnosis was appropriate.

Restraints, security and escorts

49. When prisoners have to travel outside 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.

50. After Mr Harmond's diagnosis, he attended Grantham and District Hospital for chemoradiotherapy. During escort to hospital he was restrained by the use of an escort chain. (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.) On arrival the escort chain was removed to allow him to receive medical treatment.

51. Mr Harmond was admitted to Grantham Hospital on 25 June with increased pain. He remained in hospital for 11 days. He was not restrained during the escort to hospital or during his stay.

52. We are satisfied that the use of restraints was appropriate and that the prison correctly reviewed their use as Mr Harmond's condition deteriorated.

Liaison with Mr Harmond's family

53. On 28 April 2017, a nurse spoke to Mr Harmond about his diagnosis and any family he wanted to contact. He did not wish to speak to anyone outside of prison as he said all his friends were in Whatton.

54. On 25 July, a prison family liaison officer (FLO) visited Mr Harmond in his cell to introduce himself. He explained his role as a FLO and asked if he became very unwell who he would like to be contacted. Mr Harmond said he had no next of kin. He told the FLO that the only person he wanted to be contacted when he died was his solicitor.

55. A memorial service was held at Whatton on 16 August and Mr Harmond's funeral was held the following day. The prison contributed to the cost of the funeral in line with national policy.

Compassionate release

56. 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 includes that the risk of reoffending 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.

57. On 16 May 2017, Mr Harmond put his case for release to the Parole Board. On 2 June, Mr Harmond's application was refused. The Parole Board was aware of Mr Harmond's terminal diagnosis but they felt that he still presented a high risk of

harm to children and the risk of reoffending was too great to be managed in the community.

58. On 28 June, Mr Harmond's Offender Supervisor started an application for early release. This was forwarded to Mr Harmond's Offender Manager who returned it on 3 July. The Offender Manager did not support the application, quoting the Parole Board findings in the earlier application for release.

59. The application was forwarded to the healthcare department on 3 July. A doctor did not complete the form until 20 July and the form was returned on 25 July.

60. The Governor completed the application on 27 July and it was sent to the Public Protection Casework Section (PPCS) for consideration. The following day, a PPCS caseworker contacted the prison explaining that the application needed to be amended as it had to be considered afresh and could not take into account anything the Parole Board had said in its decision letter. The caseworker also required a full medical report from the hospital oncologist and a full risk management plan from his Offender Manager including a care plan and details of future accommodation. Mr Harmond died two days later, before the application could be reconsidered.

61. It is unacceptable that it took the healthcare department 22 days to return the compassionate release paperwork. Had the application been completed without this delay (and with the extra documentation required), the application may have been considered before Mr Harmond's death. We make the following recommendation:

The Governor and Head of Healthcare at HMP Whatton should ensure that applications for early release on compassionate grounds are progressed without delay.

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