Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sydney Head a prisoner at HMP Elmley on 14 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 Sydney Head died on 14 June 2017 at HMP Elmley of a blood infection due to blood and bone cancer. He was 87 years old. We offer our condolences to Mr Head's family and friends.

We agree with the clinical reviewer that the standard of healthcare Mr Head received at Elmley was equivalent to that which he could have expected to receive in the community. Prison healthcare staff made an appropriate urgent referral to a hospital specialist when Mr Head presented with his cancer symptoms, facilitated subsequent hospital visits and provided compassionate end of life care.

We are concerned that on several occasions, prison managers authorised the use of restraints for Mr Head's hospital visits and that managers' risk assessments were inconsistent. The Governor needs to ensure that all prison managers understand and properly apply the risk assessment process for hospital transfers.

We are disappointed, once again, to have found inappropriate decision-making in relation to the use of restraints. We have previously made recommendations, which the prison has agreed to implement, to address these repeat failings. Urgent action is needed now and we bring this matter to the attention of the Director of Kent and Essex Prisons.

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

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

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Summary

Events

1. Mr Sydney Head arrived at HMP Elmley on 6 June 2014. He was a frail man in poor health. On 4 February 2016, a prison GP noted that Mr Head's blood count had deteriorated and referred him to the hospital haematology department.

2. Mr Head underwent a bone marrow examination on 19 July and was subsequently diagnosed with acute myeloid leukaemia (a cancer of the blood and bone marrow). Specialists considered that active treatment with chemotherapy would not be in Mr Head's best interests and that his treatment should be limited to managing his symptoms and pain relief. Prison healthcare staff arranged for Mr Head to attend hospital appointments to receive blood transfusions and provided palliative care, focusing on pain management.

3. On 2 June 2017, a prison GP arranged with hospital staff to admit Mr Head as he was losing weight and had an infection. Mr Head spent 11 days in hospital receiving antibiotics.

4. On his return to Elmley, healthcare staff continued with his pain relief and making sure Mr Head was comfortable. Mr Head's condition deteriorated and he died on 14 June.

Findings

5. The clinical reviewer found that healthcare staff appropriately referred Mr Head to hospital. We consider that prison healthcare staff managed Mr Head's care well and the standard of healthcare was equivalent to that which he could have expected to receive in the community.

6. The investigation found that some prison managers authorised the inappropriate use of restraints when Mr Head was taken to hospital, having not fully taken into account Mr Head's medical condition and mobility. We also found that the prison did not notify Mr Head's family when he was seriously ill in hospital. We make three recommendations.

Recommendations

- The Governor and the Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Director of Kent and Essex Prisons should assure himself that meaningful action is taken to ensure that this happens.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

The Investigation Process

7. 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. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Head's prison and medical records. She interviewed one member of staff on the telephone on 12 July and three members of staff at HMP Elmley on 13 July 2017.

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

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

11. The investigator wrote to Mr Head's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She said that prison staff had not maintained contact with her when Mr Head's health deteriorated and she asked about his care.

12. The investigation has assessed the main issues involved in Mr Head'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. Mr Head's daughter received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Elmley

15. 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

16. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided a calm and well run environment with good care for prisoners with the most acute needs. Palliative care pathways were used appropriately and sensitively.

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 1 November 2016, the IMB reported Elmley's outpatient department continued to run efficiently with a very caring team, monitoring and caring for a wide variety of chronically ill prisoners and staff in the prison's inpatient department were commended for their continuing excellent care under sometimes very challenging conditions.

Previous deaths at HMP Elmley

18. Mr Head was the tenth prisoner to die of natural causes at Elmley since January 2016. We have raised the issue of the unjustified use of restraints several times before. There has been one death from natural causes since, which is still under investigation.

Findings

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

19. On 6 June 2014, Mr Sydney Head was sentenced to 18 years for sexual offences and sent to HMP Elmley. He was in poor health with a number of chronic conditions including asthma, lung disease, kidney disease, heart problems, high blood pressure and multiple deep vein thrombosis (which left him with eczema and skin ulcers). He was also profoundly deaf and had restricted mobility.

20. Throughout Mr Head's first year and a half in prison, healthcare staff saw him frequently to review his lung and heart conditions. GPs treated him with antibiotics and pain relief, and referred him to hospital when necessary. Healthcare staff created care plans to help Mr Head manage his asthma, lung disease, personal hygiene and continence care, and to assist him to move around.

21. Prison GPs arranged routine blood tests to monitor Mr Head's conditions. In September 2014, a prison GP noted that Mr Head's blood test results showed he had mild anaemia. He arranged for a second test six days later, the results of which were normal.

22. Mr Head's blood test results in December 2014 showed that he was again mildly anaemic. He had the same result again in January 2015. A prison GP prescribed iron tablets for three months.

23. In September 2015, further blood tests showed Mr Head's blood count had deteriorated. In addition, he was losing weight and had experienced a change in bowel habits. The prison GP referred him to the colorectal team at hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Head had tests but there was no evidence of cancer. He was discharged with no further follow up.

24. On 20 October 2015, further abnormalities of Mr Head's blood count were noted. He was referred to a haematologist at hospital for further assessment. Haematology staff reviewed him on 10 December 2015. They noted that his blood counts had improved and were stable. They discharged Mr Head and noted that blood tests should be repeated in two or three months.

25. On 4 February 2016, a GP examined Mr Head as he had lost weight, had a low blood count and complained of bowel problems. The GP again referred him to hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. The colorectal team at hospital did not reinvestigate as they had found no evidence of cancer four months previously.

26. Mr Head had several hospital appointments as hospital haematology specialists investigated reasons for his low blood count. Following a bone marrow examination on 19 July 2016, hospital staff diagnosed acute myeloid leukemia (a cancer of the blood and bone marrow).

27. The clinical reviewer said that the mild anaemia detected in 2014 was probably a result of Mr Head's chronic diseases, rather than an iron deficiency. He

considered that treating Mr Head with iron tablets was inappropriate. Nevertheless, he added that the incidents of mild anaemia occurred before Mr Head became unwell and therefore, he would not have expected doctors to have made a referral to the haematology department at that stage. He also considered that the lack of such a referral did not impact on the timing of Mr Head's diagnosis.

28. We agree with the clinical reviewer that overall, Mr Head's care was of a good standard.

Mr Head's clinical care

29. After Mr Head's diagnosis, hospital staff advised that active treatment with chemotherapy would not be in his best interests and that treatment should be limited to managing his symptoms and palliative care. They said Mr Head needed monthly blood transfusions to maintain his haemoglobin levels and prison healthcare staff needed to check his levels every fortnight.

30. Healthcare staff at Elmley created care plans for Mr Head and monitored him regularly. They arranged for him to attend hospital for blood transfusions. Prison nurses helped him clean and dress and gave him pain relief. Records show nurses cared for him well. Prison staff appointed a prisoner carer to help Mr Head. He collected his meals and helped him in his wheelchair to move around the prison.

31. On 2 June 2017, a prison GP reviewed Mr Head. He noted he was confused, had diarrhoea and was only eating and drinking in small quantities. He diagnosed a possible infection and arranged with hospital staff at hospital to admit him. Hospital staff arranged a blood transfusion and intravenous antibiotics for Mr Head.

32. On 13 June, hospital staff discharged Mr Head back to Elmley. He was not eating or drinking and Mr Head's consultant told the head of healthcare, that Mr Head was deteriorating and should receive end of life care.

33. On return to Elmley a nurse reviewed him. She noted he had a catheter for draining his urine. He was unable to eat or drink and had diarrhoea. She cleaned him and made him comfortable. In the early hours of the morning, she contacted the out of hours doctor for advice as she noted Mr Head appeared to be hyperventilating. The doctor recommended medication to help relax his breathing and that his next of kin should be contacted.

34. At 4.45am on 14 June, a nurse noted Mr Head was unresponsive but breathing. She completed his personal care and at 5.05am, she noted he had stopped breathing, his pupils did not react to light and there was no pulse. At 9.20am, a locum prison GP declared that Mr Head had died.

35. Mr Head had expressed a wish that he did not want to be resuscitated if his heart or breathing stopped and had signed an order to that effect.

36. The Coroner gave Mr Head's cause of death as neutropenic sepsis (a white blood cell infection) due to acute myeloid leukemia (blood and bone marrow cancer).

37. We agree with the clinical reviewer that Mr Head's care and treatment in prison was equivalent to that which he could have expected to receive in the community. Staff cared for Mr Head well and maintained his dignity throughout his decline. The clinical reviewer has made recommendations for the head of healthcare and NHS Commissioner to consider concerning medical administration procedures, which are not repeated in this report.

Mr Head's location

38. Mr Head spent time between a residential wing and the inpatients unit. When he was on the residential wing, he was on the ground floor in a cell with wheelchair access. Mr Head had told staff that he enjoyed being on a residential unit as he felt less isolated and enjoyed the freedom of his door being open during the day so prisoners could visit him. Nurses visited him daily to ensure his healthcare needs were met.

39. As Mr Head's condition deteriorated, it became clear that he required 24 hour nursing care. He moved permanently to the inpatient healthcare unit from May 2017. We are satisfied that Mr Head was appropriately located throughout his illness.

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.

41. 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.

42. Mr Head attended many hospital appointments at the Infusion Suite for his blood transfusions. Several prison managers completed escort risk assessments.

43. A selection of assessments undertaken after Mr Head's terminal diagnosis have been reviewed. Many of the assessments had healthcare input that noted that Mr Head had cancer, heart and lung disease and was a wheelchair user. It was encouraging to find that some prison managers authorised that restraints should not be used. However, some managers, after assessing the same information, concluded that Mr Head should be restrained.

44. On 26 February 2017, a prison manager authorised the use of single handcuffs and then 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). He said that he took into account that the medical section of the assessment noted that Mr Head was a physically frail, elderly wheelchair user and noted there were no medical objections to the use of restraints. He said the

risk to the public was also taken into account including that he was a sex offender and posed a risk of harm to children.

45. On 1 June, a prison manager authorised the use of single handcuffs for Mr Head's transfer to hospital. He said that he was aware of the previous hospital visits but he did not check the previous assessments. A nurse had completed the medical assessment and noted that Mr Head was a wheelchair user and there were no medical objections to the use of restraints. The prison manager said he had had reservations about the lack of detail in the medical assessment, but he did not seek further information.

46. It is clear that the risk assessments completed by managers who authorised the use of restraints did not take into account Mr Head's health and lack of mobility at the time, or their impact on his risk of escape. His medical record noted that he could mobilise only short distances and used a wheelchair to get around. Records indicate that he found it difficult to get in and out of bed and could barely walk. He was unable to collect his meals and needed help for all his care needs. It is difficult to see how the use of restraints was justified, not least as he was also escorted by prison staff.

47. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. All staff involved need to ensure that a prisoner's health and mobility are fully taken into account in risk assessments for the use of restraints in line with the guidance in the 2007 High Court judgment. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that all healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We repeat the recommendation, which we have made several times before to the Governor. Given the repeat nature of this recommendation, we address a further recommendation to the Governor's manager:

The Governor and the Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Director of Kent and Essex Prisons should assure himself that meaningful action is taken to ensure that this happens.

Liaison with Mr Head's family

48. Mr Head's daughter was his next of kin. She said that she had not been notified of some of Mr Head's hospital admissions. She said she made unnecessary journeys to the prison and was then told he was in hospital. She said on 8 June 2017, she contacted the prison to arrange to visit her father. Prison staff did not tell her that he was in hospital and they booked the visit for 2 July.

49. When Mr Head's condition in hospital deteriorated on 13 June, managers at HMP Elmley asked a chaplain and an officer as trained family liaison officers, to visit Mr Head's daughter to inform her. However, when staff arrived at her home no one was in and there was no response to telephone messages. They went to Mr Head's grandson's address but no one was home so they left a message asking someone to contact them. Contact was made with Mr Head's daughter later that afternoon. She complained that she had not been informed that her father had been in hospital. As hospital staff were finalising arrangements for Mr Head's discharge, she asked for arrangements to be made for her to visit her father in prison in a few days time. Sadly, Mr Head died before this happened.

50. On 14 June, the family liaison officers visited Mr Head's daughter to inform her Mr Head had died. On 26 June, Mr Head's family visited Elmley to meet the Governor and view Mr Head's accommodation. They also complained about some aspects of his care and the lack of contact when Mr Head was seriously ill in hospital.

51. Elmley contributed to the cost of Mr Head's funeral in line with national guidance.

52. On 25 September, the governor apologised to Mr Head's daughter for the delay in informing her of her father's death but explained that the prison was required to break the news in person as soon as possible. She said they would endeavour to use discretion in future.

53. The Governor acknowledged there had been a problem on 8 June when Mr Head's daughter had not been informed that her father was in hospital. She said the process had been revised to improve procedures.

54. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill.

55. We are concerned that on some earlier hospital admissions, no one contacted Mr Head's daughter. When Mr Head was admitted to hospital on 2 June, the prison should have informed his next of kin. The prison missed the opportunity on 8 June to rectify this when Mr Head's daughter contacted them. This meant that neither his daughter nor other family members had the opportunity to visit and spend time with Mr Head before his death. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

Compassionate release

56. 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.

57. Prison staff considered the possibility of compassionate release and obtained information from Mr Head's consultant haematologist in May 2017. She said his prognosis was less than 12 months. When Mr Head's health deteriorated on 12 June, the hospital consultant said that Mr Head had deteriorated and that end of life care may be appropriate. As the application for compassionate release was being considered, Mr Head died. We are satisfied that the prison appropriately considered Mr Head for compassionate release.

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