Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Kinloch a prisoner at HMP Holme House on 18 January 2018

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.

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 John Kinloch died in hospital from complications of liver cancer on 18 January 2018 while a prisoner at HMP Holme House. He was 53 years old. I offer my condolences to Mr Kinloch's family and friends.

The care Mr Kinloch received was not equivalent to that which he could have expected to receive in the community. There were indications from the end of November 2017 that he was becoming increasingly unwell and a doctor found him to be malnourished. The doctor referred Mr Kinloch for investigations but he was not monitored by nurses in the meantime and was not seen by the duty response nurse on 12 December despite a request from an officer. Mr Kinloch was eventually sent to hospital on 27 December when found collapsed in his cell.

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 **August 2018**

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Summary

Events

1. On 16 March 2007, Mr John Kinloch was sentenced to a minimum of three years and two months in prison for robbery and possession of an imitation firearm. As he was approaching the end of his sentence he absconded from an open prison and later left an approved premises without authority. He was recalled to custody on 21 June 2017 and was transferred to HMP Holme House on 26 June.

2. On 8 December 2017, Mr Kinloch told a prison doctor that he had been unwell for a month with nausea and vomiting. The doctor found that he was malnourished and had a tender and enlarged liver. The doctor arranged for tests.

3. On 12 December, an officer asked for the duty response nurse to visit Mr Kinloch after she saw him lying curled on his side in bed. The duty response nurse did not visit him.

4. On 27 December, staff asked a doctor to visit Mr Kinloch. The doctor believed that Mr Kinloch was in early septic shock and he instructed that Mr Kinloch be sent to hospital. Hospital investigations found that Mr Kinloch had liver cancer and he then deteriorated rapidly from associated complications.

5. Mr Kinloch died in hospital at 8.55am on 18 January 2018.

Findings

6. The clinical reviewer found that Mr Kinloch received a standard of care that, overall, was not equivalent to that which he could have expected to receive in the community.

7. We agree with the clinical reviewer that an absence of formal processes meant that Mr Kinloch was not seen by the duty response nurse on 12 December. In addition, no arrangements were made for him to be monitored by nurses when he was found to be malnourished and test results indicated that he had complications arising from his hepatitis C.

8. We consider that the use of restraints when Mr Kinloch was first admitted to hospital was reasonable given his absconding history.

9. We are satisfied that the prison began the process for early release on compassionate grounds, although Mr Kinloch died before the arrangements could be progressed.

Recommendations

- The Head of Healthcare should ensure that there is a robust system in place so that prisoners referred to the duty response nurse are triaged and seen on the day of referral if appropriate.

- The Head of Healthcare should ensure that healthcare investigation results are communicated to the primary care team with nursing support and monitoring put in place as appropriate.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Kinloch's prison and medical records. He interviewed six members of staff at Holme House on 14 March 2018 and subsequently spoke to three other witnesses by telephone.

12. NHS England commissioned a clinical reviewer to review Mr Kinloch's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed staff.

13. We informed HM Coroner for Teesside of the investigation. The Coroner gave us Mr Kinloch's cause of death. As the cause of death was known, a post-mortem examination was deemed unnecessary. We have sent the Coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Kinloch's next of kin, his brother, to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. The family wanted to know about the clinical care and treatment that Mr Kinloch was receiving, and any diagnoses, in the weeks preceding his admission to hospital. They wanted to understand whether notice was taken of their brother's weight loss and jaundiced skin and whether he should have been sent to hospital sooner. The family also wanted to know whether the prison considered the option of compassionate release from custody.

15. The investigation has assessed the main issues involved in Mr Kinloch's care, including his diagnosis and treatment, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

16. Mr Kinloch's family received a copy of the draft report. They raised a number of issues which we have dealt with in separate correspondence. The response from HMPPS to our recommendations is included as a new annex.

Background Information

HMP Holme House

17. HMP Holme House is a medium security prison, which holds around 1200 convicted men. Health services at the prison are delivered by several different providers. The prison has an inpatient unit and nurses are on duty 24 hours per day.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Holme House was in July 2017 and took place at a time when Holme House was being transformed from a local prison holding mainly remand prisoners, to a training prison for low risk convicted prisoners. Inspectors reported that the health interactions that they observed were very good, but they noted chronic staff shortages in the primary care nursing team that had affected service delivery. In their survey, only 22 per cent of prisoners said that the quality of health services was good. Many prisoners complained about long waiting times and inspectors found that prisoners were waiting up to five weeks for routine doctor and nurse practitioner appointments. They did find, however, that patients with urgent needs were seen quickly.

Independent Monitoring Board

19. 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 31 December 2017, the IMB reported that plans were in place to restructure the delivery of primary care but that the plans had been compromised by significant staff shortages including difficulties in the recruitment and retention of healthcare staff.

Previous deaths at HMP Holme House

20. Mr Kinloch's death was the ninth death at Holme House since February 2016. Of those deaths, seven were from natural causes. There are no similarities between this and the previous deaths.

Key Events

21. On 16 March 2007, Mr John Kinloch received an indeterminate sentence of a minimum of three years and two months in prison for robbery and possession of an imitation firearm. He was sent to HMP Rye Hill. He was transferred to HMP Garth on 24 September 2013 and on 8 April 2015 was moved to open conditions at HMP Kirkham.

22. Mr Kinloch absconded from Kirkham in September 2015 but within a few days he was taken back into custody at HMP Preston. He was transferred to HMP Lancaster Farms on 10 December 2015 and on 8 March 2017, was released on licence to an Approved Premises. Mr Kinloch breached his licence conditions by leaving the premises and not returning. On 21 June 2017, he was recalled into custody at HMP Durham.

23. On 26 June 2017, Mr Kinloch was transferred to HMP Holme House. At an initial health screen, he said that he had no concerns about his physical health. His height was recorded as 1.70 metres (5 feet 7 inches) and his weight was 59.5 kilograms (9 stones 5 pounds). The nurse noted that Mr Kinloch had been diagnosed with hepatitis C in 1997 (hepatitis C is a virus that can infect and damage the liver). Mr Kinloch was moved to the therapeutic community on A wing on Houseblock 6 (the therapeutic community helps severe drug misusing prisoners with the aim of changing their attitudes and behaviour).

24. For the first few months after he arrived at Holme House, Mr Kinloch's only contact with healthcare services was for dental treatment.

25. On 29 November, Mr Kinloch told a nurse that he had stomach cramps and that he felt unwell. Mr Kinloch was advised to rest in his cell for 24 hours.

26. On 6 December, Mr Kinloch told a pharmacy technician who was dispensing medication that he was feeling very sore with aching joints. She advised him to rest until a doctor's appointment that was booked for 8 December.

27. On 8 December, Mr Kinloch saw a prison doctor. Mr Kinloch said that he had been unwell for a month with nausea and vomiting. He said that he had lost his appetite, although he was starting to eat again. Mr Kinloch's weight was now 51.7 kilograms (8 stones 2 pounds), which the doctor noted meant a loss of 8 kilograms (17 pounds) since June. Mr Kinloch said that his bowel habits were normal with no blood in his faeces. The doctor noted that Mr Kinloch's liver was tender and enlarged. At interview, the doctor said that Mr Kinloch's problems with periodic weight loss dated back to 2005 and was not an unusual symptom for people with hepatitis C. The doctor prescribed Fortisip nutrition drink and referred Mr Kinloch for a chest X-ray, for an ultrasound scan and to the hepatology clinic.

28. On 12 December, an officer was visiting Houseblock 6 when a prisoner told her that Mr Kinloch was in his cell and was unwell. The officer went into Mr Kinloch's cell where she found him lying on his bed and curled up on his side. He told her that he was not feeling well and had been feeling the same way for several weeks. The officer telephoned the communications room and asked them to send a message to the healthcare unit to say that Mr Kinloch was poorly and

needed to be seen that day by the duty response nurse (the nurse responsible for urgent but non-emergency referrals).

29. The officer's message was logged by the healthcare unit at 2.19pm. At 5.18pm, the duty response nurse noted in Mr Kinloch's record that she had not had time to see him before the end of her shift so she passed the task to the evening duty nurse.

30. The evening nurse did not visit Mr Kinloch. He said that he did not receive a verbal handover from the duty response nurse, instead, she had entered Mr Kinloch's name in the ledger of patients who were still waiting to be reviewed. The evening nurse said that he had been extremely busy on the evening of 12 December and had not been able to review the patients in the ledger. At interview, the Head of Healthcare said that he would expect the duty response nurse to find out more about the referred patients to help gauge the urgency and priority of each patient.

31. On 14 December, Mr Kinloch's offender supervisor tried to interview Mr Kinloch for a parole report. He said that Mr Kinloch seemed unwell; he was grey in colour and he sounded as if he had influenza-type symptoms. Mr Kinloch said that he was awaiting the result of blood tests. He said that he did not feel well enough for an interview that day so his offender supervisor postponed the interview.

32. On 19 December, his offender supervisor went to see Mr Kinloch again. He said that Mr Kinloch looked worse that day than he had been five days earlier; he looked very grey and pale. Mr Kinloch agreed to a meeting that day but his offender supervisor thought this was only because he wanted a little bit of time out of his cell.

33. On 21 December, a doctor noted in Mr Kinloch's records that the results from the ultrasound scan showed that he had an enlarged spleen and liver as well as masses in his liver that required further investigation. The doctor confirmed at interview that he did not see Mr Kinloch that day as other investigations were still ongoing.

34. A unit manager on Houseblock 6 said that he recalled one member of staff from the Therapeutic Community mentioning that Mr Kinloch was unwell but none of his officers referred any concerns to him or reported that Mr Kinloch appeared jaundiced.

35. In the late morning of 27 December, staff from Houseblock 6 contacted healthcare to say that Mr Kinloch was feeling weak and would need assistance to attend a nurse's appointment that was set for the following day. A doctor and nurse went to see Mr Kinloch in his cell. The doctor said that Mr Kinloch was jaundiced, was emaciated and had a high temperature. His diagnosis was early septic shock and he instructed that Mr Kinloch should be sent to hospital. An ambulance arrived at 11.52am and took Mr Kinloch to North Tees General Hospital. Mr Kinloch remained in hospital for the next three weeks while investigations were made. They found that he had a liver tumour, which on 17 January was confirmed to be malignant. Mr Kinloch died at 8.55am on 18 January.

Contact with Mr Kinloch's family

36. A prison manager telephoned Mr Kinloch's mother on the afternoon of 27 December to inform her that her son had been admitted to hospital and she gave her the hospital telephone number. Another prison manager visited Mr Kinloch on 1 January 2018 and he asked her to tell his family that a doctor had told him that there was a 99 per cent chance that he had cancer. She telephoned the family and they visited him over the following days. Mr Kinloch's brother was with him on the morning of his death. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

37. A unit manager debriefed the officers who were with Mr Kinloch when he died. The staff care team also offered support.

38. The prison posted notices informing other prisoners of Mr Kinloch's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Kinloch's death.

Cause of death

39. A post-mortem was not carried out, however Mr Kinloch's treating physician gave his cause of death as Spontaneous Tumour Lysis Syndrome caused by a malignant tumour. (Tumour lysis syndrome is a potentially fatal complication when tumour cells are killed and released into the bloodstream. This can occur during cancer treatment but can also occur spontaneously in the absence of treatment.)

Findings

Clinical care

40. The clinical reviewer found that Mr Kinloch's care was not equivalent to that which he could have expected to receive in the community.

41. The clinical reviewer was critical of the general management of Mr Kinloch's nutrition. She noted that while his weight was recorded sporadically in recent years, no use was made of approved screening tools to determine his risk of malnutrition. Nor was there any evidence that Mr Kinloch's nutritional intake and weight was monitored after a doctor saw him on 8 December and prescribed a dietary supplement due to his high risk of malnourishment.

42. The clinical reviewer was also critical of the lack of any formal process to triage prisoners referred to the duty response nurse. Instead the nurse appeared to have simply worked through the list of referred names. This meant that Mr Kinloch was not seen on 12 December when he was referred to the duty response nurse and no one from healthcare saw him until 27 December, when he was found collapsed in his cell.

43. The clinical reviewer also pointed out that when the ultrasound scan results were reviewed by the doctor on 21 December and noted to contain adverse findings, the results were not discussed with Mr Kinloch or with the primary care team. Nor were nurses tasked to monitor him pending the outcome of further investigations. We make the following recommendations:

    The Head of Healthcare should ensure that there is a robust system in place so that prisoners referred to the duty response nurse are triaged and seen on the day of referral if appropriate.

    The Head of Healthcare should ensure that healthcare investigation results are communicated to the primary care team with nursing support and monitoring put in place as appropriate.

Restraints

44. 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.

45. When Mr Kinloch was taken to hospital on 27 December, a nurse completed the healthcare section of the escort risk assessment to show that there were no medical objections to the use of restraints and that Mr Kinloch had no medical

conditions that would prevent him from escaping. It was noted that Mr Kinloch had absconded from prison in September 2015 and a manager decided that Mr Kinloch should be escorted by two officers and that a single handcuff and escort chain should be used.

46. On 2 January 2018, one of the appointed family liaison officers visited Mr Kinloch. She discussed Mr Kinloch's prognosis with a senior nurse and then telephoned a governor at Holme House to discuss the continued need for restraints. The governor advised that due to Mr Kinloch's history of absconding he should remain on an escort chain pending a definitive clinical diagnosis and prognosis.

47. Mr Kinloch's escort records show that he spent much of his time watching television and chatting to the escorting officers. The escort chain was removed at times to allow Mr Kinloch to have a shower.

48. In the early evening of 5 January, a prison manager reviewed the continued need for restraints. He noted that although Mr Kinloch remained undiagnosed, he was physically weak and was unlikely to attempt to escape or to cause any other problems. He authorised removal of the escort chain. Mr Kinloch remained unrestrained thereafter.

49. We are satisfied that the use of an escort chain was appropriate when Mr Kinloch was taken to hospital. Although he was told on 31 December that he almost certainly had cancer, this diagnosis was not confirmed definitely until 17 January. Mr Kinloch's records show that staff reviewed the continued need to use restraints in the days following Mr Kinloch's hospital admission and they appropriately took into account his recent history of absconding from prison and of leaving an approved premises without authorisation. We are pleased that the restraints were removed on 5 January when a prison manager recognised that Mr Kinloch's condition by then was such that he was unlikely to attempt an escape.

Compassionate release

50. 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) 4700. The criteria include 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 HM Prison and Probation Service.

51. On 16 January, a nurse from Holme House visited Mr Kinloch due to his deteriorating condition. She noted that he was due to have a biopsy that day to determine if his tumour was malignant and also noted that the doctors caring for him had indicated that he was terminally ill.

52. On the afternoon of 17 January, a consultant gastroenterologist at North-Tees hospital emailed a letter to Holme House to say that Mr Kinloch had extensive cancer of the abdomen and that he was likely to die in the next few weeks. Given the prognosis, the consultant wrote that she supported his release on compassionate grounds to a nursing home in Glasgow where most of his family lived. On receipt of the letter, Holme House started the process for compassionate release. Mr Kinloch died at just before 9.00am the following morning before Holme House were able to make any significant progress with arrangements for compassionate release. We are satisfied that the prison acted appropriately and make no recommendation.

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