

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James McLean a prisoner at HMP Hull on 17 May 2018

A report by the Prisons and Probation Ombudsman

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 James McLean died of liver failure and colon cancer on 17 May 2018 while a prisoner at HMP Hull. He was 80 years old. I offer my condolences to Mr McLean's family and friends.

I am satisfied that the care that Mr McLean received at Hull was equivalent to that which he could have expected to receive in the community.

I am, however, concerned that prison managers adopted a default position for the use of restraints when escorting Mr McLean to hospital even though he was elderly and frail and undergoing tests for liver disease and cancer. This appears to be a structural problem at Hull which needs to be addressed.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

November 2018

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Summary

Events

1. On 11 August 2014, Mr James McLean received an 11-year sentence for sex offences and was sent to HMP Hull.
2. On 29 September, healthcare staff found that Mr McLean had pernicious anaemia (a lack of red blood cells due to a lack of vitamin B12), for which he had monthly injections of hydroxocolamin.
3. Mr McLean remained well until 18 March 2018, when he saw a nurse because he had stomach pains, including a pain in the right side of his abdomen. The nurse noted that his right side was tender. She referred him to a GP.
4. A prison GP sent Mr McLean for an ultrasound test and blood tests under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks, and then for a chest x-ray. The scan showed that Mr McLean had liver disease which had spread from the right lower part of his abdomen. The chest x-ray showed that his lungs were clear.
5. A prison GP identified that Mr McLean might have bowel cancer, and referred him to the colorectal (bowel) team at Hull Royal Infirmary. On 26 April, a liver consultant at Beverley Community Hospital saw Mr McLean. He asked for an urgent CT scan (an imaging procedure that uses x-rays to create detailed scans). He did not make a diagnosis.
6. On 1 May, because Mr McLean was unwell, healthcare staff sent him to the Wellbeing Unit for closer observation. On 10 May, when his condition was much worse, healthcare staff moved Mr McLean to the palliative care suite, where he received one-to-one nursing care. On 14 May, a Macmillan nurse saw Mr McLean and healthcare staff put an end of life care plan in place.
7. On 17 May, Mr McLean died of liver disease and colon cancer. A nurse and a healthcare assistant were with him when he died.

Findings

8. The clinical care that Mr McLean received was equivalent to that which he could have expected to receive in the community. Prison GPs appropriately referred him for scans and tests under the two-week wait rule. When healthcare staff found that he had lost weight, they completed a nutritional assessment and prescribed him nutritional supplements.
9. We are satisfied that when Mr McLean's health got worse, he moved from a standard cell to the Wellbeing Unit. There was a delay in moving him to the palliative care suite because the profiling bed ordered for him did not arrive for five days. Despite this, healthcare staff provided Mr McLean with good care in the Wellbeing Unit.
10. Healthcare staff appropriately asked for advice and support from Macmillan nurses. Mr McLean had access to end of life care, and he died in comfort and with dignity.

11. In the absence of a suitable address for Mr McLean's release and a diagnosis of a terminal illness or prognosis of less than three months, it was reasonable and in line with policy that staff did not complete a compassionate release application.
12. Even though Mr McLean's level of restraint was reduced to an escort chain on 11 April and removed on 26 April, prison managers defaulted to using a single cuff for Mr McLean when taking him to hospital because he was a Category C prisoner. The medical risk assessment noted no objections to the use of restraints, even though Mr McLean was elderly, seriously unwell and was considered a low risk of escape and to the public. Hull should have taken Mr McLean's individual circumstances, including his age, health and risk into account when deciding whether or how to restrain him. As in another death which we have recently investigated at Hull, there is no evidence that they did so.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 Prison Group Director, Yorkshire, should assure himself that effective steps are taken to stop the inappropriate use of restraints for hospital escorts.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr McLean's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr McLean's clinical care at the prison.
16. We informed HM Coroner for East Riding and Kingston-Upon-Hull of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The investigator wrote to Mr McLean's niece who was his next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
18. We assessed the main issues involved in Mr McLean'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.
19. We shared the initial report with the Prison Service. There were eight factual inaccuracies and this report has been amended accordingly. Their action plan has been appended to this report.

Background Information

HMP Hull

20. HMP Hull is a local prison, which holds up to 1,044 prisoners in ten wings. City Healthcare Partnership provides health services at the prison. The prison closed its healthcare inpatient unit in October 2014, and it became the Wellbeing Unit to support and progress prisoners with healthcare complex needs which are difficult to meet in a standard prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.
21. In August 2018, the prisons minister announced that Hull would be one of the prisons participating in the '10 Prisons Project'. The project (with the aid of a 10 million pound funding injection) seeks to improve safety, security and decency at the prisons by focussing on living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. The team offered an appropriate range of primary care clinics, within an acceptable timeframe. Social care assessments were timely and the provision was reasonably good.

Independent Monitoring Board

23. 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 2015, the IMB noted that the prison is effectively run, provides a safe environment for all and has benefited from the strong leadership of the current Governor and Management Team.
24. The IMB noted that there was a full health screen at reception, which identified immediate risks and outpatient clinics to manage long-term medical conditions. However, the Board had received many complaints, mostly about medication and prescribing issues.

Previous deaths at HMP Hull

25. Mr McLean's death was the fifteenth at Hull since May 2015, nine of which have been from natural causes. In December 2016, we made a recommendation about the inappropriate use of restraints, which Hull agreed to implement. We have since identified continuing concerns in this area which we have escalated to the Prison Group Director.

Findings

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

26. Mr McLean was serving an 11-year sentence for sex offences and had been at HMP Hull since the beginning of his sentence on 11 August 2014.
27. On 29 September, healthcare staff found that Mr McLean had pernicious anaemia, for which he had monthly injections of hydroxocobalamin. While at Hull, healthcare staff prescribed him medications for pain relief, to prevent constipation, to increase his weight, to prevent nausea and vomiting and to treat anxiety.
28. On 18 March 2018, Nurse A saw Mr McLean because he said that he had stomach pains and a pain in the right side of his abdomen. Mr McLean had tenderness on his right side and a slightly raised temperature (36.8 degrees). She referred him to a GP.
29. On 20 March, Dr A, a prison GP, saw Mr McLean. He told the doctor that he had pain in his abdomen, had not been eating well and had lost weight. It was not clear if his weight loss was gradual or happened over a short period of time because there had been no previous clinical need to weigh him. The doctor referred him urgently for an ultrasound scan and blood tests under the two-week wait rule. He had blood tests on 29 March.
30. On 3 April, Dr A saw Mr McLean. The blood tests were abnormal and because Mr McLean had lost weight, the doctor referred him for a chest x-ray, also under the two-week wait rule. The chest x-ray showed that Mr McLean's lungs were clear.
31. On 16 April, Mr McLean went to hospital for the ultrasound scan. The results showed that his liver was very enlarged and was damaged. The scan showed that the liver disease had spread to Mr McLean's right lower abdomen.
32. On 18 April, Dr B, a prison GP, reviewed Mr McLean. The doctor noted that Mr McLean was frail, underweight and that his liver was palpable and hard. He was concerned that Mr McLean had upper gastro intestinal cancer so he referred him to the colorectal (bowel) team at Hull Royal Infirmary.
33. On 26 April, a consultant liver surgeon at Beverley Community Hospital, saw Mr McLean for the referral made by Dr B. He asked for an urgent CT scan. He told Mr McLean and the prison escort staff that he had throat cancer.
34. We are satisfied that prison GPs appropriately referred Mr McLean for scans and tests under the two-week wait rule. We are also satisfied that because Mr McLean's health deteriorated rapidly after he saw consultant liver surgeon on 26 April, who told him that he suspected that he had cancer, he did not go for the urgent, requested CT scan. When healthcare staff found that he had lost weight, they completed a nutritional assessment and prescribed him nutritional supplements.

Mr McLean's clinical care

35. On 3 May, healthcare staff referred Mr McLean to Macmillan nurses who specialise in managing pain and symptoms of cancer. On 9 May, Mr McLean fell over. Senior nurse A noted that he did not have any injuries but was very frail and confused. The senior nurse completed a falls risk assessment.
36. On 9 May, Dr B saw Mr McLean and noted that he was very frail, his abdomen was very swollen with ascites (fluid) and his feet were swollen.
37. On 10 May, Mr McLean signed an order to say that he did not want anyone to resuscitate him if his heart or breathing stopped.
38. On 14 May, a Macmillan nurse, saw Mr McLean and helped to put an end of life care plan in place for him. The nurse asked that Mr McLean have liquid oramorph for pain relief.
39. On 17 May, Mr McLean died in the palliative care suite. Nurse B and a healthcare assistant, were with him when he died. A post-mortem examination showed that he died of liver disease and colon cancer.
40. The clinical care that Mr McLean received was equivalent to that which he could have expected to receive in the community. There was a delay in moving Mr McLean to the palliative care suite because the profiling bed ordered for him did not arrive for five days. Despite this, Mr McLean received good care from healthcare staff in the Wellbeing Unit.
41. Healthcare staff appropriately asked for advice and support from Macmillan nurses which meant that Mr McLean had access to end of life care which allowed him to die in comfort with dignity.

Mr McLean's location

42. On 1 May, Dr B saw Mr McLean because he was unwell. She noted that his abdomen was swollen and that he was very pale. Mr McLean's blood oxygen saturation was low (91%) and his pulse rate was high (127 beats per minute). She noted a National Early Warning (NEW) score of seven (which indicated a serious risk of clinical deterioration and a poor outcome). Healthcare staff decided to admit Mr McLean to the Wellbeing Unit for closer observation.
43. On 2 May, when Mr McLean's health got worse, healthcare staff decided to transfer him to the palliative care suite. On 3 May, a clinical lead nurse, ordered Mr McLean a profiling bed (which allows the legs to be elevated to help reduce fluid in the legs and ankles) which arrived on 8 May. The bed only fitted in the palliative care suite.
44. On 10 May, Mr McLean moved to the palliative care suite after the profiling bed arrived. (It is unclear why he was not moved the previous day.) In the palliative care suite, Mr McLean had one-to-one nursing care.
45. We are satisfied that when Mr McLean's health deteriorated, he was appropriately moved from a standard cell to the Wellbeing Unit and then to the palliative care suite, where he stayed until he died seven days later.

Restraints, security and escorts

46. Between January and April 2018, when Mr McLean frequently went to hospital, prison staff completed a risk assessment. Mr McLean was considered a low risk of escape and a low risk to the public. During this period, prison managers reduced the level of restraint from a single cuff to not being restrained. On 11 April, when Mr McLean went to the Hull Royal Infirmary the Head of Residency and Safety, authorised that the single cuff should be replaced by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). On 26 April, Mr McLean used a wheelchair to go to hospital and the Head of Operations, authorised that he should only be restrained if his behaviour became worse. He was therefore not restrained.
47. 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.
48. 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.
49. We are concerned about Hull's approach to risk. Mr McLean was elderly (80 years old), frequently went to hospital for tests and scans because he was unwell and had a worsening, chronic liver disease. We are concerned that despite these factors, the healthcare section of the risk assessment, used before Mr McLean left the prison to attend hospital, noted that there were no objections to the use of restraints.
50. Mr McLean was a Category C prisoner, and the Acting Head of Residency and Safety, said that prison managers used the default restraint position of a single cuff for Category C prisoners. We are concerned that Mr McLean's individual circumstances, including his age, health and risk were not taken into account, as they should have been and in line with case law.
51. We recognise that Head of Residency and Safety reduced the level of restraint to an escort chain on 11 April and that the Head of Operations authorised that Mr McLean should not be restrained on 26 April. However, we have seen no evidence that Hull took into account that Mr McLean was an elderly and unwell man, at low risk of escape and to the public, when they restrained him during this period, particularly as he also had two escort officers to accompany him to hospital. We are concerned that we have identified issues with the use of restraints in another death at Hull in May 2018. We repeat the following recommendation and as with the other case, draw this concern to the attention of the Prison Group Director:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 Prison Group Director, Yorkshire, should assure himself that effective steps are taken to stop the inappropriate use of restraints for hospital escorts.

Liaison with Mr McLean's family

52. On 1 May, Hull appointed Supervising Officer (SO) A, as the family liaison officer. Mr McLean told SO A that he did not want his family (who lived in Scotland) to know that he was ill.
53. At 9.15am on 18 May, after Mr McLean died, SO A spoke to prison staff at HMP Kilmarnock with a view to asking them to inform Mr McLean's next of kin. She asked to speak to the duty manager but was told that all the managers were in the morning meeting. At 12.07pm, the Head of Residence and Safety, spoke to the duty manager at Kilmarnock, who said that they were not able to break the news of Mr McLean's death to his niece who was his next of kin. At 12.25pm, the SO spoke to the police and asked them to inform Mr McLean's niece that he had died.
54. At 4.46pm, a police officer told SO A that they could not find Mr McLean's niece but had told his brother that he had died. At 6.25pm, the SO telephoned Mr McLean's niece and offered her condolences. She remained in regular contact with her. Mr McLean's funeral took place on 13 June. Hull arranged and met the costs of the funeral in line with national instructions.

Compassionate release

55. 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 life expectancy of less than three months.
56. The Head of Operations said that prison staff considered compassionate release for Mr McLean. SO A said that Mr McLean did not want his next of kin to be told of his illness so she was unable to speak to her about a suitable address for his release. The SO said that after Mr McLean's death, she spoke to his niece who told her that she had not been in contact with him for years.
57. SO A said that she was aware of Mr McLean's failing health because she went to the monthly complex care meeting on 1 May, where he was discussed. She said that the prison had previously spoken to a hospice in Hull about other prisoners but because of Mr McLean's rapidly failing health, they decided that they did not have time to complete the application and that his poor health made it inappropriate to move him out of palliative care at the prison.
58. In the absence of a suitable address for Mr McLean's release, given that Mr McLean did not have a diagnosis of a terminal illness or a prognosis of less than three months and that his health failed very rapidly towards the end of his life, it

was reasonable and in line with policy that staff did not complete the compassionate release process for him.

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