

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Lockwood a prisoner at HMP High Down on 28 September 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*

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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.

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 David Lockwood died of lung cancer on 28 September 2017 while a prisoner at HMP High Down. He was 69 years old. We offer our condolences to his family and friends.

Mr Lockwood received a good standard of care at High Down, equivalent to that which he could have expected to receive in the community. However, there was no evidence of clear medical input in Mr Lockwood's escort risk assessments or that the compassionate release process was started as it should have been.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

Contents

Summary	Error! Bookmark not defined.
The Investigation Process.....	Error! Bookmark not defined.
Background Information.....	Error! Bookmark not defined.
Key Events.....	Error! Bookmark not defined.
Findings	Error! Bookmark not defined.

Summary

Events

1. On 15 December 2016, Mr David Lockwood was convicted of sexual offences and sent to HMP Wormwood Scrubs. On 26 January 2017, he was transferred to HMP High Down
2. During his initial healthcare induction, Mr Lockwood told a nurse that he had anxiety but no other health concerns.
3. On 14 April 2017, Mr Lockwood had pains in his chest and was prescribed antibiotics. When the pain continued, a doctor referred him for a chest x-ray and asked for a biopsy to be taken under the two week rule for suspected cancer.
4. Mr Lockwood was diagnosed with cancer of his lungs in early July. On 14 July, a scan of his lungs showed that his condition was terminal and that there were no potential treatment options.
5. On 25 July, a multidisciplinary meeting took place to outline a plan for Mr Lockwood's care. He was referred to the mental health inreach team as his anxiety worsened after his diagnosis.
6. The healthcare team continued to monitor Mr Lockwood, and the community palliative care team visited the prison to oversee his care.
7. On 14 September a doctor recorded that Mr Lockwood had reached the last weeks of his life. On 26 September, when the prison could no longer provide the care he needed, Mr Lockwood was transferred to a hospice, where he died on 28 September.

Findings

8. We are satisfied that Mr Lockwood's care at High Down was equivalent to that which he could have expected to receive in the community. When he first showed signs of being unwell, healthcare staff took the appropriate steps to ensure that his symptoms were investigated, and he was correctly referred under the two week rule for suspected cancer. When Mr Lockwood received his diagnosis, the prison appropriately appointed a family liaison officer who maintained regular contact with Mr Lockwood's partner.
9. The prison did not always take Mr Lockwood's health into consideration when assessing his escort risk, and they failed to start the compassionate release process.

Recommendations

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

- The Governor should ensure that when a prisoner is given a terminal diagnosis, staff clearly document their consideration of and decisions about compassionate release.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Lockwood's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Lockwood's clinical care at the prison.
13. We informed HM Coroner for Surrey of the investigation who provided us with the cause of death. We have sent the Coroner a copy of this report.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
15. Mr Lockwood's partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
16. Our investigation assessed Mr Lockwood'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.

Background Information

HMP High Down

17. HMP High Down is a local prison in Surrey, which held up to 1,150 men at the time of Mr Lockwood's death. Central and North West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

18. The most recent inspection of High Down was in January 2015. Inspectors reported that health services were good overall but staff shortages resulted in too many cancelled appointments. Prisoners had prompt access to a range of pharmacy services, which reduced the need for GP appointments. Inspectors considered this good practice.

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 report for the year to December 2016, the IMB said that High Down was yet to see significant changes since the appointment of an Executive Governor when it became a reform prison in April 2016. They said that prisoners' healthcare had suffered because clinics had been cancelled due to the shortage of uniformed staff. The report for the year to December 2017 has yet to be published.

Previous deaths at HMP High Down

20. There have been three previous deaths from natural causes at High Down since January 2016. We made a previous recommendation about the use of restraints, which High Down agreed to implement.

Findings

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

21. On 15 December 2016, Mr David Lockwood was convicted of sexual offences and admitted to HMP Wormwood Scrubs.
22. On arrival, Mr Lockwood told a nurse that he had been diagnosed with an anxiety disorder as a child but had no further health concerns. She referred him to a prison GP as part of his secondary health screening and he was referred to the mental health team. Mr Lockwood confirmed that he had not seen his community GP in the months before he was admitted to prison, and was not taking any medication.
23. The mental health inreach team saw Mr Lockwood the next day and referred him for psychological intervention.
24. On 26 January 2017, Mr Lockwood was transferred to HMP High Down.
25. There are no relevant entries in Mr Lockwood's medical records until 14 April when he saw a nurse. She recorded that Mr Lockwood complained of having had a cough and shortness of breath for three weeks. On examination, she heard a crackle to the right side of his lung. On the basis of her findings, a prison GP issued a prescription for antibiotics and arranged for Mr Lockwood to see him on 21 April.
26. Mr Lockwood did not attend the appointment on 21 April, and a letter was sent to him to reschedule his appointment for 5 May. Mr Lockwood did not attend this appointment either and no reason is recorded for this.
27. On 17 May, Mr Lockwood attended an appointment with a prison GP. Mr Lockwood complained of shortness of breath, a cough and some chest pain. She noted that Mr Lockwood had not been able to climb stairs as normal, and that his ankles were showing signs of pitted oedema (swelling). She arranged for him to have a chest x-ray at hospital that afternoon.
28. Mr Lockwood remained in hospital overnight, where he was diagnosed with right side plural effusion (fluid on the lungs). His lungs were drained and he was discharged on 24 May.
29. On his return to High Down, a nurse discussed his diagnosis with him, and Mr Lockwood told her that he had pneumonia and that there was a possibility that the fluid on his lungs had accumulated as a result of a cancer. She recorded that Mr Lockwood was waiting for a biopsy under the two week suspected cancer pathway.
30. On 25 May, Mr Lockwood was admitted to hospital after he was recorded as having an abnormally fast heart rate. This needed to be treated before having the biopsy (as a fast heart rate meant that he was not suitable for a general anaesthetic).

31. On 20 June, Mr Lockwood was admitted to hospital for a biopsy of his lungs. Mr Lockwood was discharged on 23 June, with a comprehensive discharge summary which outlined his aftercare and medication to manage his conditions.
32. On 25 June, Mr Lockwood complained of shortness of breath and a sharp pain at the location of the biopsy. A nurse took his saturation levels which were recorded at 80% (low) and, although they were raised with oxygen therapy, an ambulance was called and Mr Lockwood was admitted to the Coronary Care Unit at hospital. He was placed on cardiac medications and given intravenous antibiotics. On 30 June, he was discharged to High Down.
33. On 6 July, the healthcare department at High Down received a letter from hospital which confirmed Mr Lockwood's diagnosis of mesothelioma (cancer of the lungs). A prison GP arranged an appointment with Mr Lockwood that day to discuss the results. His medical records include a note of an in-depth conversation with Mr Lockwood about his condition and management options.
34. It was noted that Mr Lockwood's diagnosis might exacerbate his anxiety, and a prison GP referred him to the mental health services.
35. During the period that diagnostic procedures were undertaken, a care plan was put into place to support Mr Lockwood's physical and mental health.
36. Mr Lockwood was admitted to hospital on 14 July for a positron emission tomography (PET) scan of his lungs. (A PET scan is used to produce a detailed three-dimensional image.) The image showed that Mr Lockwood's condition was terminal and that there were no treatment options for his condition.
37. When Mr Lockwood first presented with symptoms of chest pain, he was prescribed an antibiotic to manage what was believed to be a chest infection. A follow-up appointment was arranged which Mr Lockwood did not attend. A subsequent appointment was arranged which he again did not attend. The clinical reviewer said that it was reasonable for the GP to assume that Mr Lockwood's symptoms had resolved and that if he had not attended such an appointment in the community, a GP would not have pursued it.
38. When Mr Lockwood went to see a doctor as he had swelling to his ankles in addition to chest pain, he was appropriately referred for investigation. After cancer was suspected, he was referred under the two week rule for a biopsy of his lungs.
39. There is clear evidence in Mr Lockwood's medical records that staff supported him and kept him informed throughout the process. When he was informed of his diagnosis, a thorough care plan was implemented to address his physical and psychological needs.

Mr Lockwood's clinical care

40. On 11 July, a prison GP recorded a plan to discuss whether Mr Lockwood wanted to be resuscitated in the event of a cardiac or respiratory arrest. Mr Lockwood decided that no attempt should be made to resuscitate him but that he wanted to receive all other appropriate treatment and care. There is medical

evidence that the document recording this decision not to resuscitate him accompanied Mr Lockwood to all his external hospital appointments.

41. On 25 July 2017, a multidisciplinary meeting took place. The Head of Safety, the Head of Healthcare, a security custodial manager, the Head of Offender Management and the Deputy Governor attended. An administrator took a note of the meeting and noted the need for counselling, palliative support and a referral to the pagan chaplaincy.
42. As Mr Lockwood was not receiving any treatment to manage his illness, he was prescribed co-codamol and paracetamol to relieve pain. The palliative care team visited Mr Lockwood on 7 August and advised him to continue with co-codamol. They referred Mr Lockwood to see their own psychological team to come to terms with his diagnosis and prognosis.
43. On 10 August, a prison GP saw Mr Lockwood and changed his prescription to liquid morphine as the co-codamol was making him feel sick. She also prescribed a nutritional liquid supplement for his weight loss. She noted that Mr Lockwood was low in mood and was becoming increasingly anxious due to his condition. She referred him to the mental health inreach team.
44. Duty nurses and the mental health team continued to review Mr Lockwood weekly. On 14 August, a prison GP diagnosed Mr Lockwood with anxiety disorder and prescribed medication to manage this.
45. On 23 August, the palliative care team visited and asked for anticipatory medication to be prescribed. (For adult palliative care patients who are actively deteriorating and are in the last weeks or days of life, it is good practice to provide anticipatory medication to control symptoms.) A prison GP prescribed this the next day.
46. The healthcare team continued to monitor Mr Lockwood. They encouraged him to remain active until it was no longer possible.
47. On 14 September, a prison GP recorded that Mr Lockwood had reached the last weeks of life under the gold standard framework (a model of good practice that enables a 'gold standard' of care for people who are nearing the end of their lives). He noted that Mr Lockwood would benefit from hospice care. He noted that Mr Lockwood's document which advised not to resuscitate him remained above his bed, and was visible to all staff.
48. Mr Lockwood's health deteriorated further. He was unable to eat much and was becoming increasingly weak. On 26 September, a nurse and the palliative care team made the decision to transfer Mr Lockwood to a hospice as High Down was unable to provide medication by a syringe driver
49. Mr Lockwood was transferred that same day, and died in the hospice on 28 September.
50. We agree with the clinical reviewer that Mr Lockwood's condition was well managed at High Down, and equivalent to the care that he could have expected to receive in the community. Regular multidisciplinary meetings took place to ensure that both Mr Lockwood's physical and emotional needs were addressed,

and the clinical reviewer said that there was evidence that healthcare staff followed national guidance by proactively planning for Mr Lockwood's palliative care.

Mr Lockwood's location

51. Mr Lockwood was advised to stay in the healthcare department while his symptoms were investigated. He agreed to do so. When he returned to High Down from hospital on 24 May, Mr Lockwood had a discussion with a nurse about his location. Mr Lockwood wanted to return to standard location, and she agreed that he could do so but that he must use his cell bell if he needed anything. She said that if his health deteriorated, he could be admitted to the healthcare centre.
52. Mr Lockwood remained on standard location. After an admission to hospital on 25 June, he returned to the healthcare centre.
53. On 28 July, a prison GP referred him to a hospice and Mr Lockwood was transferred there on 26 September when he was nearing the end of life.

Restraints, security and escorts

54. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as a prisoner's health and mobility.
55. Mr Lockwood went to hospital many times throughout his illness. We reviewed the risk assessments for the last six months before his death. On 14, 19, 25 June and 12 and 18 July 2017, Mr Lockwood's risk to the public, of escape and hostage taking was assessed on three occasions as medium and on two occasions, as a low risk. Although the risk was variable, he was double cuffed for each escort.
56. On each risk assessment, it was recorded that during a previous hospital admission on 17 May, Mr Lockwood had spoken inappropriately about young children and was found with a pair of scissors in his possession
57. While this decision to double cuff may have been appropriate given Mr Lockwood's actions on 17 May, we do question whether this was fully proportionate to the risk he posed, which should have been considered in light of his age and physical health. At each risk assessment, there was limited input from medical staff. They noted no concerns about Mr Lockwood being cuffed, but did not explain why, and they did not assess, as they should have, the impact of his physical condition on his ability to escape unaided.
58. Staff completing risk assessments should always consider the risk a prisoner poses at that time, taking into account any current and relevant information, particularly medical opinion about the prisoner's ability to escape. We note that Mr Lockwood was not restrained when he was transferred to the hospice on 26 September. We make the following recommendation:

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

Liaison with Mr Lockwood's family

59. On 4 July, after Mr Lockwood was told of his diagnosis, a security custodial manager was appointed to make contact with his next of kin. She maintained regular contact with Mr Lockwood's partner and agreed to contact her when he died (as his partner was too unwell to visit the hospice). She spoke to her on 28 September after Mr Lockwood's death, and arranged to visit her the next morning.
60. Mr Lockwood's funeral took place on 14 December. The prison has not yet been invoiced for the funeral expenses but has agreed to contribute £3,000, in line with national policy.

Compassionate release

61. 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) 6000. 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 Prisons and Probation Service.
62. Mr Lockwood's medical records indicate that he was nearing the end of his life from 23 August, and on 14 September, a prison GP noted that he had weeks left to live.
63. The investigator found no information in Mr Lockwood's prison records that the early compassionate release procedures had been started as they should have been, but was told by the Deputy Governor, that had taken place conversations to address this subject.
64. High Down gave the investigator minutes of the multidisciplinary meetings which took place on 3 and 31 August. Although these contained information about Mr Lockwood's risk which suggested why he might not be suitable for compassionate release, there is no evidence to suggest that the prison fully considered compassionate release, or started the application. We therefore make the following recommendation.

The Governor should ensure that when a prisoner is given a terminal diagnosis, staff clearly document their consideration of and any decisions about compassionate release.

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